INTRODUCTION

Developing Home Visiting in Wisconsin Through Shared Practice and Mentoring is a joint effort between the Department of Children and Families (DCF) and the Department of Health Services (DHS), supported by additional partner agencies, the Department of Public Instruction (DPI) and Children's Trust Fund (CTF). This initiative builds on the existing partnerships and work promoting prevention services that will strengthen and expand home visiting services to Wisconsin's highest risk families. Wisconsin's Updated State Plan for a State Home Visiting Program reflects an evolving system that is developing a strong foundation upon which to build and be successful. The purpose of Wisconsin's application for an ACA Development Grant is to provide further capacity and resources and include additional high-risk communities that can benefit from our foundational activities to implement evidence-based Early Head Start (EHS), Healthy Families America (HFA), and Parents as Teachers (PAT) home visiting programs. To further support these efforts, we propose the development of a tribal population-focused and two regional *Communities of Practice (CoP)* for those that work in or support home visiting programs, as well as the establishment of a home visiting *Mentor-Protégé Program* that pairs experienced evidence-based home visiting programs with programs that are newly implementing or transitioning to that model.

While Wisconsin has a long history of working across systems to develop interconnected, early childhood services, the availability of home visiting that reflects quality, proven practices has often been underfunded and slow to develop. This has resulted in many communities lacking quality, proven home visiting programs to support at-risk families. Additional ACA resources will build state capacity to support more at-risk communities while state leaders also develop model and cross-model training, technical assistance, and evaluation infrastructures. And, while Wisconsin is committed to sustaining the current state and federal funds allocated to existing home visiting programs, a development grant will further leverage available resources as well as position us to successfully compete for future ACA and other funding opportunities. Furthermore, Wisconsin's proposed robust evaluation, particularly in relation to the innovative CoP and mentor-protégé programs, will provide valuable information for the field about how to build state capacity for adopting, implementing, and sustaining evidence-base home visiting programs.

The MIECHV competitive grant proposed project, *Developing Home Visiting in Wisconsin Through Shared Practice and Mentoring,* is designed to address the following Priority Elements of HRSA and ACF:

- Priority Element 2: To support effective implementation and expansion of evidence-based home visiting programs and systems with fidelity to the evidence-based model selected.
- Priority Element 3: To support the development of statewide home visiting programs.

The intent of the ACA Development Grants are for states and jurisdictions that currently have modest home visiting programs and want to build on existing efforts. This grant application will support Wisconsin's initial steps toward building high-quality, evidence-based home visiting programs as part of comprehensive early childhood systems by expanding resources to more at-risk communities while intentionally connecting the expansion to other key early childhood

system efforts of the Wisconsin's Early Childhood Advisory Committee (ECAC). While building the infrastructure to support all at-risk communities and promote quality home visiting services throughout Wisconsin, this grant also expects to: improve maternal, child, and family health in urban Milwaukee County by expanding evidence-based home visiting services to cover a larger geographic area, and targeting those services to teen parents and immigrant and refugee populations (Priority Element 1); expand support to sovereign Tribal Nations in rural Northern Wisconsin to implement evidence-based home visiting services (Priority Element 7); and support development of innovative strategies to reach high-risk and hard-to-engage populations in all at-risk communities throughout the state (Priority Element 5).

Wisconsin believes that all children should have the opportunity to grow up in safe, healthy and nurturing environments. When families are unable to provide an optimal environment for their children, we want to ensure they have access to a wide range of high quality services wherever they reside. We believe these services should be provided to families in neighborhood locations where they are already utilizing services, including schools, child care centers, and in their homes. We believe it is critical to provide a continuum of prevention and early intervention services to families that meet their individual needs. Thus, it is our goal to develop a comprehensive early childhood system in Wisconsin with a continuum of service strategies, including a mixture of home visiting models. We believe it is imperative that our continuum of services adequately addresses our cultural and ethnic diversity, including programming specific to Tribes and immigrant and refugee populations.

With support from the MIECHV competitive grant, Wisconsin will continue its work toward development of a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety and development, as well as strong parent-child relationships. Specifically, expanded home visiting services will be intensive, comprehensive and focus on services to children prenatally to age five, and seek to improve the well-being of children and families. Wisconsin has adopted the following guiding principles for the development and implementation of a statewide plan for supporting evidence-based home visiting models.

1. Emphasize **depth over breadth** in order to maximize the likelihood of achieving desired outcomes.
2. Focus on **promoting collaboration** with existing services, including health care providers and economic support to build a comprehensive coordinated system.
3. **Promote sustainability** through building community capacity for programs to thrive after the initial grants from the state.
4. **Emphasize outcomes** with evidence-based models through high levels of model fidelity
5. **Prioritize service delivery to at-risk populations.**

Home visiting services in Wisconsin prioritize the following three outcome areas:

- Reductions in child maltreatment
- Improvements in school readiness and achievement
- Improvements in maternal and child health

Through our efforts, we will build an integrated early childhood system that will demonstrate:

- Improvements in family stability and economic self sufficiency
- Improvements in parenting skills related to child development
- Reductions in family violence
- Improvements in the coordination and referrals to other community resources, services and supports
- Reductions in emergency department visits

Wisconsin's Home Visiting Initiative will build on existing efforts, including the work of the Governor's State Advisory Council on Early Childhood Education and Care (ECAC), co-chaired by the Secretary of the Department of Children and Families and the State Superintendent of Public Instruction. The ECAC was created in December 2008 with the charge to develop a statewide strategic foundation for an effective early childhood system in Wisconsin.

The Wisconsin Early Childhood Comprehensive Systems (ECCS) grant, the Wisconsin Early Childhood Collaborating Partners (WECCP), and Project LAUNCH will also be critical components in embedding home visiting services into a statewide comprehensive early childhood system. Wisconsin's ECCS project is designed to increase coordination and integration of medical homes, mental health, early care and education, family support and parent education to foster collaborative work and promote the healthy growth and development of children from birth to school entry. WECCP has realigned its work to support this effort. Project LAUNCH is focused on promoting five evidence-based prevention programs that support young children and families. Linking with the State MCH program's five year early childhood initiative begun in 2010 to strengthen local community use of *Bright Futures* will also enhance the home visiting system plan.

Through this work and the ECAC, Wisconsin has made substantial progress in creating a comprehensive early childhood system. Much remains to be done, including developing a system that allows data sharing across programs, e.g. the number and types of home visiting programs, populations served and participant outcomes. As a result, the quality of services and the degree to which Wisconsin home visiting programs are producing the desired outcomes and reaching at-risk families is not fully known. These additional funds will further Wisconsin's investment in a statewide infrastructure to support evidence-based programs.

Please see Attachment 1 for the Project Logic Model.

NEEDS ASSESSMENT

A Case for Expanding Evidence-Based Home Visiting in Wisconsin

Wisconsin is a rich blend of urban and rural communities with distinct challenges facing each area. Sixty-one percent of Wisconsin's population lives in 25 metropolitan counties, while the remaining 39% live in the 47 non-metropolitan counties. In 2008, there were 72,002 live births to Wisconsin residents. The estimated number of children under age 18 was 1,317,847 or about one-fourth of the state's population. Although 86% of the state's population is primarily non-Hispanic white, Wisconsin has become increasingly culturally diverse, with an estimated 14% of

the population comprised of African Americans, Hispanic/Latinos, American Indians, and Asians.

Wisconsin's child population is more diverse than the adult population. In 2008, people of color made up 22% of the population under the age of 18, and only 8% of the adult population over 45. From 1998 – 2008, the proportion of Wisconsin births to non-Hispanic whites decreased from 81% to 74.5% while the proportion of births to Hispanics about doubled (5% to 10%). The proportion of births to women in other racial/ethnic groups remained roughly stable, with births to African American women accounting for 10% in both 1998 and 2008, American Indians approximately 1.5% each year, Laotian or Hmongs approximately 2% and women in other ethnic and racial groups (Chinese, Japanese, and Korean) accounting for 2% each year.

The needs assessment required by the MIECHV program identified 18 at-risk communities based on the federal indicators. Wisconsin added an indicator for the *percent of minority population* to help address racial disparities. Eliminating racial and ethnic disparities in birth outcomes is a priority in Wisconsin as evidenced by the significant focus on this issue in the Healthiest Wisconsin 2020 plan. During the past 20 years, infants born to Wisconsin African American women have consistently been 3-4 times more likely to die within the first year of life than infants born to Caucasian women, generally due to greater than average numbers of premature births and very low birth weights. State data indicates that: (http://www.dhs.wisconsin.gov/wish/main/data_sources.htm)

- In 2008, higher percentages of premature infants (< 37 weeks) were born to women of color, teens, women with less than a high school education and women who smoked while pregnant when compared with the overall proportion of premature infants in the State.
- In 2008, women of color were more likely to give birth to low-birth weight babies than white women.
- In 2008, women of color, particularly African American women, were at significantly higher risk to experience the death of their infants within the first year of life.

The 2008 Wisconsin data on the required indicators established the baseline against which indicators for at risk communities are compared. Standard metrics were used to collect and describe Wisconsin statewide data on key indicators obtained from state reporting systems. The communities identified as being at risk were compared to the state benchmark and the lowest ranking 25% were determined to be at-risk communities.

Wisconsin's need fro a strong system of evidence-based home visiting programs is based on: high percentages of preterm and low birth weight infants; high rates of infant mortality, especially among our African American population; and high rates of substance abuse, especially binge drinking. In addition, the state has fairly high rates of reported child abuse and neglect. The recent recession exacerbated these dismal statistics with higher unemployment rates leading to increases in child poverty and more domestic violence.

Since Wisconsin has a state supervised, county administered system for many services, there are wide variances in the resources available at the community, county, regional and tribal level. Wisconsin communities face distinct challenges such as racial/ethnic disparities in birth

outcomes, lack of available resources, births to teen parents, smoking during pregnancy, substance abuse or isolation due to location and language barriers. These unique challenges make it difficult for the State to prescribe one particular evidence-based home visiting model. Wisconsin currently has five of the evidence-based models identified in the Home Visiting Evidence of Effectiveness (HomVEE) review operating: Early Head Start, Healthy Families America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse Family Partnership (NFP), and Parents as Teachers (PAT).

During the last decade, Wisconsin provided home visiting dollars to eleven communities through general purpose revenue and Temporary Assistance for Needy Families (TANF) to pilot home visiting programs. These programs were based on the *12 Critical Elements of the Healthy Families America Model, but* the programs were not required to affiliate with a national model. Additional dollars were garnered to provide training and technical assistance to sites for professional development of the staff delivering the services and administering the programs. It was intended that home visiting would be implemented statewide in subsequent years, but attempts to allocate additional funding from the state general purpose revenue were not successful. With the availability of the federal funding, Wisconsin intentionally blended the GPR and TANF with funding available through the MIECHV to build on the available resources and create one, coordinated system with the expectation that all home visiting programs receiving state support will use an evidence-based model.

In keeping with the guiding principle of "depth over breadth", the State made a commitment to fund a small number of programs through a Request for Proposals (RFP) process, allocating approximately $2.7 million in combined state and federal dollars including MIECHV funds, with sufficient support to fully develop and implement a high quality evidence-based program. Each of the five funded sites ranked in the top ten of the identified at-risk communities and the awards will provide services to families in 7 of the 18 identified communities at risk. The availability of Development grant dollars allows support to provide funds to additional programs at the onset of our work with the evidence-based home visiting model developers and more rapidly increase state home visiting system capacity.

Through the RFP process, communities selected to receive funds from the formula ACA dollars are: City of Milwaukee Health Department for Empowering Families, Green County, Lac Courte Oreilles Tribe in Sawyer County, Northwoods Home Visiting Program for Lincoln, Oneida, and Forest Counties, and Racine County. The following details the specific community characteristics and capacity of current ACA funded sites to implement evidence-based home visiting programs in Wisconsin including risks, strengths, need and local service systems.

The primary goals and objectives Wisconsin's current Home Visiting Program build upon the success of integrated efforts and addresses key gaps found in the assessment of early childhood program sectors, specifically in the communities that were identified as high risk through the home visiting needs assessment process. The Home Visiting State Plan identifies relevant strategies to address the gaps in services found and describes the intent to begin the development of a comprehensive, sustainable early childhood system that is accessible for all children in Wisconsin. The State leaders initiated a focus on the high risk communities that were identified in Wisconsin's home visiting needs assessment who demonstrated community capacity, program

readiness, and commitment to quality in responses to the FRP home visiting dollars. While all the sites are using the funding to build on existing home visiting or family support programs, they have varied degrees of experience with their selected evidence-based home visiting model. Funded agencies are:

Empowering Families of Milwaukee (EFM): Milwaukee County is an urban community in the Southeastern Region of Wisconsin with a population of 594,833 according to the 2010 census data. In 2008 the total number of births in Milwaukee County was 15,353 of which 9,170 or 59.7% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 72,138 children under the age of 5 in Milwaukee County and an estimated 23.1% of these children live in poverty.

Green County: Green County is a rural area in the Southern Region of Wisconsin comprised of 25 small villages and towns with a total of 36,842 residents according to the 2010 census. In 2008, the total number of births in Green County was 390 of which 156 or 40% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 2,242 children under the age of 5 in the Green County and an estimated 10.1% of these children live in poverty.

Lac Courte Oreilles Tribe (LCO): The Lac Courte Oreilles Tribe is located in Sawyer County, a rural area in the Western Region of Wisconsin with a population just over 17,000. In 2008 the total number of births in Sawyer County was 194 of which 142 or 73.2% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 3,861 children under the age of 5 in Sawyer County and an estimated 23.8% of these children live in poverty.

Northwoods Home Visiting Program: Lincoln, Oneida, and Forest Counties (LOF): Northwoods is a Northern Wisconsin Regional consortium home visiting program that will initiate and expand evidence-based home visiting program using the HFA model in a rural three-county area. Forest County is comprised of 15 small villages and towns with a total population of 9,605 according to 2010 census data. The Forest County Potawatomi Community and the Sokaogon Chippewa Community have reservations in Forest County. In 2008 the total number of births in Forest County was 98 of which 46 or 46.9% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 562 children under the age of 5 in the Forest County community and an estimated 24.0% of these children live in poverty. Lincoln County is comprised of 20 small villages and towns with a total population of 29,404 according to 2010 census data. In 2008 the total number of births in Lincoln County was 317 of which 146 or 46.1% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 1,661 children under the age of 5 in the Lincoln County community and an estimated 12.7% of these children live in poverty. Oneida County is comprised of 20 towns and the city of Rhinelander with a total population of 35,930 according to 2010 census data. In 2008 the total number of births in Oneida County was 320 of which 185 or 57.8% were paid for by the Wisconsin Medicaid Program. It is an estimated that there are 1,639 children under the age of 5 in the County and an estimated 13.9% of these children live in poverty.

Racine County: Racine County is an urban area in the Southeastern Region of Wisconsin with a population of 195,408 according to 2010 census data. In 2008 the total number of births in Racine County was 2,673 of which 1,380 or 51.6% were paid for by the Wisconsin Medicaid

Program. It is estimated that there are 13,736 children under the age of 5 in the County and an estimated 14.5% of these children live in poverty.

Estimated Number of Families to be Served by Initial State Home Visiting Plan

Program	# MIECHV Funded Families	# Total Funded Families
Empowering Families of Milwaukee	34	350
Green County	18	47
Lac Courte Oreilles Tribe	18	45
Northwoods (Lincoln, Oneida, Forest)	11	25
Racine County	27	40
Totals:	108	527

Using MIECHV Funds to Support Expansion of Evidence-based Home Visiting Programs
With ACA Development Grant funds, additional awards will be made to 5 programs representing 11 of the 18 at-risk communities that responded to the RFP. These agencies providing home visiting in high risk communities were not funded due to lack of available resources. This expansion strongly supports implementation activities to achieve priority element 3.

- Expand capacity in Milwaukee County:
  - Aurora Family Services: $634,727 for 100 families
  - Next Door Foundation: $388,385 for 54 families
- Expand Tribal capacity: Great Lakes Intertribal Council: $900,000 for 100 families
- Rock County: $330,294 for 50 families
- Brown County: $590,294 for 186 families

Total $2,843,700 for 490 families

The following details the specific community characteristics of the five new sites, including risks, strengths, need and local service system.

Aurora Family Services and the Next Door Foundation in Milwaukee County:
Aurora Family Services (and their partner organizations Rosalie Manor and the Parenting Network) and the next Door Foundation would be a part of the continuum of services for families in Milwaukee.

Milwaukee County is an urban community in the Southeastern Region of Wisconsin with a population of 594,833 according to the 2010 census data. In 2008 the total number of births in Milwaukee County was 15,353 of which 9,170 or 59.7% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 72,138 children under the age of 5 in Milwaukee County and an estimated 23.1% of these children live in poverty.

Community Strengths
City of Milwaukee community organizations and agencies are working to collaborate on addressing the issues facing the largest city in the state of Wisconsin and the 25th largest city in the nation. There are many initiatives working to address the challenges facing families in Milwaukee but the efforts are often not coordinated. Some of the most promising initiatives that

are directly related to home visiting include: Project LAUNCH, the Lifecourse for Healthy Families (LIHF) Initiative, and the Home Visiting Community of Practice.

Risk Factors

Risk Factor	Demographic Characteristic
Segregation	Milwaukee was identified as the most segregated large metropolitan area in the country for blacks and whites, and seventh most segregated between Hispanics and whites (Brookings Institute, 2010). A recent study at Emory University found that racial segregation is associated with very preterm (<32 weeks gestation) and moderately preterm (32-36 weeks gestation) births in African Americans, but not in whites. The researchers assert that segregation alone accounts for 28% of geographic variation in black-white birth outcomes disparities (Kramer, 2010).
Infant Mortality Rate	Milwaukee's overall IM rate was 11 per 1,000 births in 2009, the seventh worst city in the country. The black IM rate is nearly 2 ½ times higher than the white IM rate: 15.7 per 1,000 for African Americans vs. 6.4 per 1,000 for whites. In the most recent Fetal Infant Mortality Report, nearly three quarters of the infants who died were born prematurely, before 37 weeks gestation.
Prematurity	Prematurity was a factor in the deaths of African American babies nearly five times more often than in the deaths of white and Hispanic babies (Michalski, December 2010). A number of factors can contribute to prematurity, such as low socioeconomic status, smoking or using drugs or alcohol during pregnancy, receiving late or no prenatal care, some sexually transmitted infections (STIs), and maternal stress (City of Milwaukee Health Department, 2011).
Teen Pregnancy	There is a large racial disparity between white, African American and Hispanic teen birth rates. Teen pregnancies are overwhelmingly concentrated in the poorest areas of the city; the 2010 Milwaukee Health Report found that the lower SES zip codes have a teen birth rate 6.4 times higher than the higher SES group, 87.9 vs. 13.7 births per 1,000 15-19 year old females, respectively (Chen, 2010).
Health Disparities	The 2010 Milwaukee Health Report (MHR) examined the health outcomes and disparities across the city's higher, middle, and lower socioeconomic status zip codes. Specific examples of the disparities in Milwaukee's health outcomes by SES included the following from the 2010 MHR (lower SES zips vs. higher SES zips): infant Mortality (12.5/1,000 vs. 3.8/1,000); fair or poor self-reported health status (23.9% vs. 10.0%); no health insurance (12.5% vs. 6.5%); no early prenatal care (26.5% vs. 15.6%); smoking during pregnancy (13.1% vs. 7.6%); STD rates (31/1,000 vs. 13/1,000); seat belt non-use (18.0% vs. 8.4%); single-parent households (23.9% vs. 5.2%); and lead poisoning rates (5.2% vs. 1.5%) (Chen, 2010).
Alcohol and Drug Use	Wisconsin ranks the highest in the nation in adult alcohol consumption (67%), abuse (8%), and binge drinking (23%), and Milwaukee County's rates are at nearly identical levels at 66%, 8%, and 22%, respectively (Wisconsin Department of Health Services, Division of Public Health and Division of Mental Health and Substance Abuse, 2010). Milwaukee County ranked in the top 5 counties in the state for drug-related hospitalizations, with a rate more than 25% that of the state's overall hospitalization rate (Wisconsin Department of Health Services, Division of Public health and Division of mental Health and Substance Abuse Services, 2010).
Unemployment	Milwaukee's 2010 unemployment rate is very high at 12.4%, edging down in March of 2011 to 10.4%. Wisconsin's overall unemployment rate held at 7.4% during the same time period (Department of Workforce Development, 2011).

	Milwaukee's African American males have an unemployment rate that, at 16.4% in 2008 is nearly tripled that for whites (5.8%) and double that for Hispanics (8.1%). For Milwaukee's minority women, there is also a gap, although not as considerable: Hispanic women have the highest unemployment rate at 9.2%, compared to African Americans at 7.0% and whites ate 4.1% (University of Wisconsin-Milwaukee Employment and Training Institute, 2009).

Great Lakes Inter-Tribal Council, Inc.
Great Lakes Inter-Tribal Council, Inc. (GLITC) is a consortium of twelve federally recognized Indian tribes in Wisconsin and Upper Michigan. The GLITC mission is to support members in expanding self-determination efforts by providing services and assistance. The data is based on the information from the at-risk county in which the tribal community is located. The home visiting program will serve the following tribal and county sites:

The Bad River Band of Lake Superior Chippewa in Ashland County
Ashland County is a rural community in the Northern region of Wisconsin. The total number of births in 2008 was 198 of which 156 or 78.8% were paid for by the Wisconsin Medicaid Program. There is an estimate of 1,059 children under the age of 5 in the County and an estimated 22.9% of those children live in poverty.

The St. Croix Band of Lake Superior Chippewa Indians and Burnett County
Burnett County is a rural community in the Western Region of Wisconsin. The total number of births in 2008 was 148 of which 89 or 60.1% were paid for by the Wisconsin Medicaid Program. There is an estimate of 750 children under the age of 5 in the county and an estimated 21.9% of those children live in poverty.

Forest County Potawatomi Community and Sokoagan Chippewa Community in Forest County
Forest County is comprised of 15 small villages and towns with a total population of 9,605 according to 2010 census data. The Forest County Potawatomi Community and the Sokaogon Chippewa Community have reservations in Forest County. In 2008 the total number of births in Forest County was 98 of which 46 or 46.9% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 562 children under the age of 5 in the Forest County community and an estimated 24.0% of these children live in poverty.

The Gerald L. Ignace Health Center in Milwaukee County: Milwaukee County is an urban community in the Southeastern Region of Wisconsin with a population of 594,833 according to the 2010 census data. In 2008 the total number of births in Milwaukee County was 15,353 of which 9,170 or 59.7% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 72,138 children under the age of 5 in Milwaukee County and an estimated 23.1% of these children live in poverty. (See the chart above for further discussion of risks in Milwaukee County).

Community Strengths
The GLITC agency, tribes and counties have a long history of community-based work in the health and human services area. Effective collaborations base on respect of tribal sovereignty and community values is strength of the communities.

Risk Factors

American Indians in Wisconsin suffer from higher infant mortality rates (IMR) compared to the white race in our state. Data from the Wisconsin Department of Health Services shows that from 2006-2008 the IMR rate was 10.1 American Indian infant deaths per 1,000 births, compared to the White rate of 5.4 per 1,000. American Indian women continue to report the highest percentage of smoking during pregnancy, nearly 3 times as high as the overall state percentage.

Rock County:

Rock County is an urban community in the Southern region of Wisconsin with a population of 160,331 according to the 2010 census data. In 2008 the total number of births in Rock County was 2,076 of which 1,091 or 52.6% were paid for by the Wisconsin Medicaid Program. It is estimated that there are 10,932 children under the age of 5 in Rock County and an estimated 16.0% of these children live in poverty. Beloit, Rock County's second largest city, has a population of 36,427 with 40.8% of children under the age of 5 below the poverty line.

Community Strengths

The Rock County Home Visiting Network has worked together for ten years to increase community capacity to empower Rock county families to achieve well-being, social competence, and connectedness. Most of this effort focused on sharing information and problem solving to better coordinate services amongst members. Collaboration requires a strong trusting relationship and partners who are in full support of the goals and objectives of the initiative.

Risk Factors

Rock County and in particular the city of Beloit, are facing many stressors within their community. In 2009 births to single mothers were 47% in Rock County and 63% in the city of Beloit compared to 37% for the state of Wisconsin. In 2008 births to mothers without high school diplomas were 19% in Rock County and 25% in the city of Beloit compared to 15% statewide. In 2008 births to teen mothers was 10.2% in Rock County and 16.1% in the city of Beloit compared to 8.5% statewide. In 2009 20% of Rock County and 40.8% of Beloit children under age 5 were living below the poverty line compared to 17% statewide. In 2009 38% of the children in Rock County and 63% of the children in the city of Beloit received free and reduced lunch compared to the statewide 34%. The 2009 unemployment rate was 13% for Rock County, 17.5% for the city of Beloit and 9% for the state of Wisconsin. In 2010 Rock County Human Services Department records revealed that 46% of child abuse and neglect reported came from Beloit, with 76% of those screened in for assessment and 31% substantiated. Isolating children age 0-3; 41% of allegations were substantiated.

Brown County:

Brown County is an urban community in the Northeastern Region of Wisconsin with a population of 248,007 according to the 2010 census data. In 2008 the total number of births in Brown County was 3,451 of which 1,570 or 45.5% were paid for by Wisconsin Medicaid Program. It is estimated that there are 16,811 children under the age of 5 in Brown County and an estimated 10.1% of these children live in poverty.

Community Strengths

Brown County has a Community Partnership for Children (CPC) initiative that is a strong, comprehensive and cooperative approach to meeting the needs of families blending private and public funding. The initiative was tailored after the Systems of Care initiative in Hampton, Virginia focusing on prevention and intervention in the earliest years of a child's life. Without this focus, problems and the need for resources would only continue to escalate.

Risk Factors

An estimated 1,500 (44%) of the babies born in Brown County hospitals go home to at-risk environments according to the data collected by the CPC. The 390 highest risk families assessed in 2010 (prenatally or at the hospital) were identified as having one or more of the following risk factors: inadequate income (95%); single mother (84%); education under 12 years (35%); depression (37%); late prenatal care (21%); unstable housing (9%); and marital or family problems, including domestic abuse (21%). The community is working to develop a system of care to meet the need for early intervention in the lives of these children and families.

Home visiting programs that will be awarded Development grant funds indicated in their RFP responses that they intend to expand community capacity for HFA, Early Head Start, and PAT model programs. In addition, several communities are including the PAT curriculum within their evidence-based home visiting model. MIECHV competitive funds will allow Wisconsin to significantly enhance our training and technical assistance system and increase the likelihood of successful program implementation with a high degree of model fidelity. Developing in-state training capacity for the HFA model as well as implementing two innovations - *Communities of Practice* and *Mentor-Protégé Program* - supports priority elements 2 and 3.

Healthy Families America (HFA). Wisconsin has a long and successful history with HFA. The original Prevention of Child Abuse and Neglect (POCAN) legislation passed in 1998 created a state-funded home visiting pilot project built on the Hawaii Healthy Start program, which became the HFA national framework. Since its inception, the State required that the POCAN/Family Foundations sites adopt and adhere to the HFA *12 Critical Elements of Successful Home Visiting Programs*, and most of the PNCC-certified programs, including many home visiting programs, use the HFA Great Beginnings prenatal curriculum. Given the overwhelming interest in HFA from the communities that responded to the RFP, the State has engaged in discussions with staff from Prevent Child Abuse America, the HFA national office, to develop in-state training capacity. The goal is to use expertise that exists within the state, rather than relying more extensively on support from the national office for training and technical assistance. We recognize that while this long-run this strategy is more cost-effective, the State will need to make an initial investment in technical assistance from HFA.

Early Head Start. Wisconsin has a long and celebrated history with Head Start programs with a significant expansion in 2009 of Early Head Start through American Reinvestment and Recovery Act (ARRA) funds. Each Wisconsin program is unique and designed to best meet the needs of the local community (or communities). Wisconsin is currently home to 42 Head Start and 20 Early Head Start programs operated by 44 unique organizations–18 of which provides both Head Start and Early Head Start services. Of the 18 organizations that offer Early Head Start, seven programs offer the home-based option, generally in combination with center-based programs.

Five of the 20 Early Head Start programs are American Indian Early Head Start programs. Thought not classified as "Early Head Start," the Migrant/Seasonal Head Start program has an infant and toddler aspect that serves children from birth through age five. As of September 2010, operation of the Wisconsin Head Start State Training & Technical Assistance (T/TA) Center was assumed by STG International, Inc. (STGi), which is responsible for the T/TA centers in the six-state Midwest consortium (Region 5). Under this iteration of the T/TA System, the Wisconsin Head Start T/TA Center provides direct support and technical assistance to the state's Head Start & Early Head Start grantees to improve their capacity to deliver high quality services. Joanna Parker, principle staff person for the Wisconsin T/TA Center will remain an advisor to the ECAC Ad Hoc Committee on Home Visiting Training/TA work group, and she is committed to providing necessary support to EHS programs that will expand as a result of this competitive funding opportunity.

Parents As Teachers (PAT). In 2010, PAT celebrated its 25th anniversary and Wisconsin has been providing PAT services for nineteen of those years. Parents Plus brought the first PAT program to Wisconsin in 1992, and it was the first organization to be a designated state PAT office. Since the inception of the PAT Quality Standards program assessment, only six commendations have been given nationally. Of those, three have come to Wisconsin programs. Wisconsin PAT programs have demonstrated the highest standards in model fidelity and quality programming. There are currently 55 PAT programs employing over 300 parent educators operating in 39 Wisconsin counties. Twenty-six programs are operating in Wisconsin high-risk counties. Three of the recently selected home visiting sites have opted to embed their proposed HFA model programs with the PAT child development curriculum. The State supports the sites' use of the PAT curriculum and will continue to work with the PAT national and state offices to implement the Wisconsin Home Visiting Plan, including the 2-year expansion project.

METHODOLOGY

Developing Home Visiting in Wisconsin Through Shared Practice and Mentoring demonstration project will be administered in the state as a combination of financial support for five more programs in several additional at-risk communities and implementation of new strategies to assure quality evidence-based services are accessible to eligible families. After receiving technical assistance based on resources provided by HRSA and ACF (e.g., the Home Visiting Evidence of Effectiveness (HomVEE) review and the March 17 HRSA webinar, "Selecting the Appropriate Model for an At-Risk Community"), via the RFP process, at-risk communities selected home visiting models that best fit their goals, capacities, and needs. The communities to be funded by this Development Grant have chosen to implement Healthy Families America (HFA), Early Head Start (EHS), and Parents As Teachers (PAT) models, all of which are on the federal Health and Human Service list of approved evidence-based models. A more detailed explanation of strength of evidence for each model and its fit for each community is provided below:

<u>City of Milwaukee, Next Door Foundation, EHS-HV with PAT Curriculum</u>
Although EHS-HV is a relatively young program, it has already been subject to an independent, national-level randomized controlled trial, yielding four moderately rigorous studies, and demonstrating 28 favorable impacts across 3 domains (child development and school readiness,

positive parenting, and family economic self-sufficiency; effect size range from .12 to .25). Although based on a single sample, the studies suggest potential long-lasting effects of the program; at least one favorable impact in all three domains was sustained for at least one year after program inception and lasted for at least one year after program completion. Only two unfavorable or ambiguous impacts (in the economic self-sufficiency domain) were detected.

The Next Door Foundation in Milwaukee has experience implementing the EHS-HV model. The Next Door Foundation began operating an EHS program in 1996 and enhanced the program with EHS-HV in January of 2010, enrolling 147 prenatal mothers, and families and children by February 2011. In particular, Next Door has found the EHS-HV model effective in engaging Hmong and Somali families, two at-risk populations not commonly served by other home visiting programs in Milwaukee. Previous Next Door EHS program participants have also demonstrated improvements in school readiness, and the program has strong links to local HIPPY, Head Start, and Educare programs. This emphasis is in line with the State goal of improving school readiness outcomes for children, resulting directly from program services, and by connecting children to high quality early education programs as they reach preschool age.

<u>City of Milwaukee, Aurora Family Services (AFS)/Rosalie Manor (RM)/Parenting Network (PN), HFA</u>

HFA has been extensively and rigorously evaluated. According to the HomVEE review, there are 10 high quality studies and 6 moderate quality studies of the program, all conducted by independent entities, drawing from 6 different samples of participants. Wisconsin is particularly interested in the HFA model, given its demonstrated impacts across several domains, and the state's desire to recruit families with multiple risks. Studies of HFA show 30 favorable, substantive impacts of the program on child development and school readiness, child health, family economic self-sufficiency, linkages and referrals, positive parenting practices, and reductions in juvenile delinquency, family violence, and crime (effect sizes ranging from .19 to .67). In addition, HFA is one of only two home visiting programs to show favorable impacts in the domain of reductions in child maltreatment, a high priority for Wisconsin. Despite this extensive evaluation history, the HomVEE review documents only 4 unfavorable or ambiguous impacts for HFA (1 in child health; 2 in family economic self-sufficiency; 1 in linkages and referrals). At least 1 favorable impact in all 7 domains was sustained for at least 1 year after program completion.

All partnering agencies are well-aligned with the HFA approach, concepts, and core competencies. The existing Family Enrichment/Home Visiting program at AFS has used the basic tenets of the HFA model for a number of years, and current policies and procedures are aligned with practice standards delineated by the Council of Accreditation (COA), which in turn are based explicitly on the HFA model. The PN has also held official HFA designation in the past. Moving to official HFA accreditation will therefore be a natural and beneficial process for this program. The embedding of this home visiting program within the health care delivery system acknowledges and addresses the HFA model's limitation around maternal health outcomes. With the PN's experience with both PAT and HIPPY, the collaboration will explore curriculum standardization as the initiative moves forward, merging the strengths of HFA and these evidence-based approaches, supporting program flexibility in choosing a curriculum that will best meet the needs of the clients.

The Aurora Sinai Women's Health Center will be the initial point of contact for clients and will serve as the medical home for the families involved in the project. Families will be connected to the other partners based upon the family needs. Aurora Family Services will serve families with mental health, alcohol and drug abuse, women with chronic illness, families with infants in the Neonatal Intensive Care Unit (NICU) and families experiencing domestic violence. Rosalie Manor will serve women nineteen years and under. The Parenting Network will serve low income families with environmental stress and multiple children.

Rock County (Beloit), HFA

According to their RFP, Rock County has also chosen to implement HFA because it provides a framework for program development and implementation that can be replicated within existing home visiting programs. This is crucial for the County, as it has a number of long-standing home visiting programs that adhere to a variety of "best practice" strategies in home visiting and working with families, and use respectable curriculums, but, with the exception of an exiting Early Head Start program, none use an evidence-based home visiting model. The 12 Critical Elements identified by HFA clearly lend themselves to the needs of Rock County, which "does not need another program," but needs to increase the capacity of its existing programs. The County feels that fully implementing HFA will help it accomplish that goal.

The HFA model components support a community-based, family-centered, strengths-based approach in which home visitors and Family Support Workers (FSW) help families build their own abilities to manage life's challenges. This is consistent with the values and beliefs under which current Rock County programs operate. Based on a review of the needs and a service gap analysis of communities within Rock County, it is the intention of the Home Visit Network Comprehensive Home Visitation Project HVN-CHV to target expanded home visiting services to African American families in the City of Beloit.

GLITC, 4 tribes, City of Milwaukee, Burnett County, HFA

GLITC also plans to implement HFA, to expand and provide more comprehensive home visiting services than provided by the current Honoring Our Children program employed by a number of Wisconsin tribes. According to the group's submitted RFP, the partnering tribes, Burnett County, and GLIICH all agree that the HFA model is the most culturally sensitive, most appropriate for the high risk families to be served, and that the model should work well in both American Indian and non-Indian households.

GLITC has a significant history and expertise with community-based work. The HFA model will fit well with other projects targeted to improve the health of women, children and families in the community including the Honoring Our Children Project in existence for 15 years, the Community Based Doula project implemented in 2010, and the Coordinated Services Team Initiative implemented five years ago. The existing services coordination systems will be used to incorporate the new home visiting initiative program goals, objectives and activities. The established advisory committees will be modified to include representatives from HFA, Lac du Flambeau Domestic Abuse, Indian Child Welfare and DCF staff.

Brown County, HFA and PAT

Brown County plans to expand its successful multi-agency early childhood collaborative with the MIECHV funds. The HFA program at Family Services of Northeast Wisconsin will be expanded to serve an additional 140 high-need families, as well as further develop their partnerships with the public health department HFA-trained PNCC providers that work with teen parents, and add staff to two local family resource centers to add capacity to their PAT programs.

The Brown County HFA program has a long history of model fidelity, and it is one of the few fully accredited sites in Wisconsin. The previous program leader served on the National HFA Accreditation Panel which further contributed to the program's adherence to the model, and this has been sustained through the current program leadership as well. Additionally, the organization as a whole, having committed to agency-wide accreditation through the Council on Accreditation, has embraced the value of following best practice standards to achieve successful outcomes in its work with families. This program will be a tremendous asset as we develop in-state capacity to deliver and expand HFA services.

In addition to HFA, Brown County also proposes to expand its PAT programs. According to the HomVEE review, there have been 2 high quality and 2 moderate quality independent studies of PAT, yielding 5 favorable impacts for the full sample on primary measures in child development and school readiness and positive parenting practices (effect sizes ranging from .20 to .25). Impacts in both domains were sustained for at least one year post program inception, and favorable impacts in child development and school readiness were replicated in at least one other study sample. Although previous PAT evaluations have not measured impacts of the program on child maltreatment, a number of Wisconsin PAT programs are currently involved in groundbreaking work supported by The Child Abuse Prevention Fund and the *Early Years Home Visitation Outcomes Project of Wisconsin* to develop a home visitation assessment tool to measure the quality of child abuse prevention programs.

As described in the previous section, at the State level, Wisconsin has extensive experience in successfully implementing EHS-HV, HFA, and PAT. By linking additional communities to the system development activities that have been undertaken via prior MIECHV funding, use of resources are timely and optimal as we infuse these evidence-based models within the state service delivery structure. In particular, the mix of new programs proposed for Milwaukee will serve to compliment the already existing EFM and Nurse Family Partnership home visiting programs run through the City Public Health Department, and will fill previous gaps in service and strengthen the overall early childhood service system in Wisconsin's neediest county.

Home visiting programs subscribe to a theory of change that presumes short-term impacts on parenting would lead to long-term impacts on child outcomes such as health, safety and development. Support for this theory of change is grounded in analyses of model programs that describe the expected long-term impacts on parents, children, and families. For the national evidence-based models that are being advanced in Wisconsin with selection to meet the needs of families identified in our-risk communities, the following outcomes are expected with high quality services delivered with model fidelity: reduction in child maltreatment, positive parenting, child development and school readiness, improved child and maternal health,

reductions in domestic violence and crime, improved linkages to and referrals for services, and increased economic self-sufficiency of the family.

Innovations That Complement Infrastructure Development for Home Visiting in Wisconsin

Creating Regional Communities of Home Visiting Practice (CoP) in Wisconsin

Using the funds available through the MIECHV Development Grant, Wisconsin proposes to develop *Communities of Practice (CoP)* for those that work in or support home visiting programs. CoP are groups of people who share a passion for something that they know how to do and who interact regularly to learn how to do it better. (Wenger, 2007) CoP have three crucial components: shared domain, community and practice. We can apply the CoP concept to the home visiting context – front-line staff, their supervisors and program administrators as well as those that support home visiting programs as trainers, policy makers or funders share a domain, are a community with a shared agenda and are committed to a particular practice that supports vulnerable pregnant women and families with young children in their homes.

The primary goal of the CoP is to stimulate divergent and inductive thinking by encouraging first deconstruction then reconstruction of current knowledge as a strategy for interpreting new situations and solving problems with imagination. (Wesley and Buysse, 2001). Research suggest that the home visiting domain could benefit from this approach in at least four ways—1) expanding professional roles to include reflection and collaborative inquiry; 2) narrowing the gap between research and practice, especially in how to engage hard-to-reach families; 3) reducing isolation among front-line staff and supervisors; and 4) taking advantage of opportunities to translate principles such as family-centered planning into concrete policies and practices. (Wesley and Buysse, 2001).

Participants in the Home Visiting CoP will engage in joint activities and discussions so that they can learn from one another and develop a "shared practice." They will use the CoP to share resources (knowledge, information, stories, tools, ways of addressing recurring problems) at regional meetings; communicate regularly via list serves, on-line communities, or through newsletters; and take advantage of opportunities to reinforce information learned during training. Adding CoP activities as component of the evolving state training and technical assistance infrastructure for home visiting will, in turn, improve child and family outcomes, increase fidelity to evidence-based models, and increase the quality of data collected by local programs.

Wisconsin will build on the rich history developed through the State's pilot Family Foundations Program, as well as the *Early Years Home Visitation Outcomes Project*, of bringing home visiting program staff together to discuss best practices, identify solutions to complex problems, and provide feedback to the State and their professional development partners. An evaluation component will be developed to ensure that the CoP are meeting expectations of the State and participants, enhancing program quality and, ultimately, improving outcomes for families.

The state home visiting plan identified regional communities of practice (CoP) as a strategy for improving the quality of implementing evidence-based models, as well as providing a vehicle for reflective practice, focusing on supervision. Although identified as a strategy in the state plan, should Wisconsin be awarded a Development Grant, the State would expand the scope of the home visiting CoP to include front-line staff and managers/administrators, develop a CoP

specifically for programs that serve tribal communities and evaluate their effectiveness in facilitating the implementation of evidence-based home visiting models. Additionally, the State will identify mechanisms for engaging participant families in the CoP process, so that we may more effectively serve them and accurately reflect their perspectives in practice.

Setting a strategic context

Wisconsin is at a critical point in the development of its training and evaluation infrastructure to support implementation of high-quality evidence-based home visiting programs. Engaging new programs in a CoP complements training by supporting staff to "learn by doing", which supports the State's focus on the MIECHV Priority Elements 2 and 3. To be successful, state home visiting staff will need to quickly engage front line staff, supervisors, and program administrators from the local communities in CoP development to ensure ownership. State staff will also need to help program staff understand how the CoP fits into their work and shapes their practice, as well as educate program administrators about the value of staff participation. Development Grant funds will be used to support the infrastructure needs of the CoP, e.g., meeting organizing, travel costs, establishing communication mechanisms, facilitators, support for meetings, etc. DCF and DHS regional staff will assist in launching the two new CoP.

The CoP not only have significant potential to shape practice, but also, they can be a tool for policy makers and funders to learn how to best support quality, evidence-based home visiting programming in the State. Each CoP will be designed to create a direct link between "learning/training" and "performance/doing." *Short-term benefits for the CoP include*:
Organizational benefits: problem-solving, taking advantage of efficiencies in resources and time (lessens learning curve)
Individual practitioner benefits: access to expertise, makes work more meaningful, assists with challenges/barriers; shared solutions to shared problems
Long-term benefits for the CoP include:
Organizational benefits: staff retention, encourages innovation and strategic thinking, encourages planning for program sustainability
Individual practitioner benefits: skill-building – particularly critical thinking skills, professional development/developing professional identity, increases practitioner's marketability, builds new relationships
The state will benefit by expanding the impact of training and learning about issues that require a state solution quickly. In addition, establishing quality communities of practice has the potential to be replicated by other states, thus creating greater efficiencies in a field with limited resources for training and technical assistance.

Practice Innovation: Home Visiting Mentor/Protégé Program

Using MIECHV Development Grant funds, Wisconsin proposes to establish a *Home Visiting Mentor Protégé Program* that pairs programs with more experience operating an evidence-based model with a program that is newly implementing or transitioning to that model. While small business mentor programs have been gaining in popularity across sectors and around the country and increased in breadth as well as number, mentor-protégé programs in social service arenas are much rarer. Similar in concept to a small business mentor program, the Wisconsin *Home Visiting Mentor-Protégé Program* is intended to increase State capacity to implement evidence-based home visiting programs with a high degree of fidelity, increase the pool of organizations that can

effectively compete for home visiting grant funds and better position the State to take part in federal initiatives. A strong Mentor-Protégé program can complement the development of a home visiting infrastructure that includes providing funds for additional evidence-based programs, expanding opportunities for training and technical assistance, and adding resources for evaluation that will, in turn, help the State achieve its ultimate goal to serve more at-risk communities more effectively to produce positive outcomes for families.

The Wisconsin *Home Visiting Mentor-Protégé Program* reflects the State's focus on the MIECHV Program Priority Elements 2 and 3 for the development grant. While the state plan recently submitted lays out an ambitious plan to further develop cross-model standards and home visiting training for front-line staff, supervisors and program administrators, the Mentor-Protégé Program compliments that infrastructure by creating intentional peer-to-peer connections to assist developing programs in very practical ways, including but not limited to: creating policies and procedures to meet and sustain program model standards, providing program supervisors opportunities to be reflective about how they support their staff to effectively work with high-risk families, helping identify potential implementation challenges and uncovering viable solutions to overcome those challenges in a more efficient/timely manner.

While training is a critical component of the State-sponsored infrastructure of the home visiting program, there are some types of technical assistance that may be better provided by staff currently delivering an evidence-based program. Potential training/TA needs of a developing or transitioning home visiting program that may be met through a peer mentoring relationship may include: strategies for collecting clean and useful data, staffing and supervision issues, achieving and maintaining model fidelity, marketing programs to families and the public, and program sustainability.

WORK PLAN

State and local efforts over the last decade and development of the Wisconsin Home Visiting Plan created a solid foundation that will enable implementation of this development grant to be successful. See Attachment 1 for the detailed work plan outlining the three primary goals for the *Developing Home Visiting Through Shared Leadership and Mentoring development* grant proposal.

Implementation Plan

Plan to engage community

Wisconsin has used several methods to engage the 18 at-risk communities as well as other areas of the state to develop and implement the state home visiting system plan. These outreach activities will continue to serve as the platform to expand and sustain evidence-based program services throughout the state. The following describes the outreach and support for home visiting programs in Wisconsin's communities:

- *Home Visiting Website*

DCF will maintain the site with the most up-to-date information about the Wisconsin Home Visiting Program and related early childhood and family support programs and initiatives at the federal, state and local level. The site can be accessed at the following link: http://dcf.wisconsin.gov/children/home_visiting_needs_assessment/default.htm

- *Home Visiting Webcasts*

Two webcasts were conducted on August 27, 2010 and on January 6, 2011 by the Project Team to provide a statewide forum to answer questions about the application process for the MIECHV program. Future webcasts may be developed to share with home visiting programs and other public and private partners' pertinent information regarding the status of the Wisconsin Home Visiting Program implementation, plans for expansion, evaluation results, etc. Webcasts may also be used for training and technical assistance.

- *Home Visiting Newsletter*

The electronic Home Visiting Newsletter, initiated in 2011, will continue be published quarterly and will provide information on state and federal home visiting activities.

- *Home Visiting Tool Kit*

The on-line Home Visiting Tool Kit developed in 2011 will be regularly updated with resources and helpful tools to help improve home visiting in Wisconsin. The Tool Kit can be accessed at the following link:
http://dcf.wisconsin.gov/children/home_visiting_needs_assessment/tool_kit.htm

- *Technical Assistance Session*

. Additional TA sessions, similar to the well-attended event held in March 2011 for the RFP release, will be planned and offered quarterly in consultation with home visiting program staff and other key partners.

- *Tribal Engagement*

With assistance of DHS Tribal Affairs staff, all of the appropriate tribal leaders were contacted to encourage participation on the ECAC Ad Hoc Committee on Home Visiting, the two work groups related to training/technical assistance and evaluation/program improvement and to encourage them to work with their county counterparts. This served as a means for Tribal leaders to become engaged in the development of the State Home Visiting Program. Continued efforts, as well as the tribal Community of Practice, are planned to sustain these connections and foster attention to the special needs and strengths of the tribal communities as the Home Visiting Program is implemented and plans for expansion are developing.

Monitoring Implementation of Evidence-Based Home Visiting

The Home Visiting Coordinator, Performance Planner and MCH Nurse Consultant, along with the State Project Team will oversee the implementation of the home visiting models. State home visiting staff in collaboration with other key partners, such as representatives of the national home visiting models, will conduct monthly site visits for the first year of program implementation to monitor local program progress. The Project Team will continue to meet weekly for the first six months of the grant to ensure support for successful implementation of the state home visiting plan. State area administration staff from the DCF regional offices will be kept informed of the program implementation and to garner support and assistance as needed. Also newly funded sites (with these grant dollars) will be connected to the *Regional Communities of Practice* to foster peer network opportunities and encourage those more experienced programs to mentor new and developing sites.

The Training work group established to support the training and technical assistance needs of home visiting programs will continue to meet to further develop the home visiting competency framework and identify, develop, or re-tool training for home visitors (at all levels) and their supervisors that reflect those competencies. The state team along with work with the training

contractors to assure the availability of training that supports ability of the supervisory staff to maintain model fidelity and provide reflective supervision to support staff. Training and technical assistance from the model developers will also be accessed as needed as new sites are implemented

.

Data entry into the SPHERE system and any model required data system will be monitored frequently, initially monthly the first year and then quarterly, to ensure the program is accurately entering the necessary information to meet the benchmark area reporting requirements. Training on the data systems and on-going technical assistance regarding data collection, reporting and CQI activities will be provided to all sites. Monthly reports will be sent by state home visiting staff back to all programs to assure data integrity and to further guide the program in implementation. Programs will be expected to use these reports to monitor program fidelity and effectiveness and correct any variations in implementation.

Self-assessment tools or implementation and quality assurance guides are provided by both Early Head Start and Healthy Families America. State home visiting staff, regional mentors, and training/TA contractors will also be available to assist programs to ensure effective use of the self-assessment tools. In addition, the State is exploring partnership with the *Early Years Home Visitations Outcomes Project* on the development and field testing of a quality assessment tool. These tools will be used to guide the implementation process. Each home visiting program will be able to provide continuous quality improvement through the use of data to:

- review the ability of staff to engage families,
- track the attrition and retention rates of families, and
- assess the gaps in services available to families.

Plan for professional development and training

Enhancing the home visiting training/technical assistance system

An essential component of a comprehensive state home visiting system that will help ensure that programs meet the federal benchmarks involves the development of a high quality training/technical assistance system. Toward this goal, DCF and DHS established a training and technical assistance workgroup, under the auspices of the ECAC Ad Hoc Committee on Home Visiting, co-chaired by two appointed members of the ECAC, Lilly Irvin-Vitella, Executive Director of Supporting Families Together Association (SFTA) and Suzy Rodriguez, Director of Parents Plus of Wisconsin, the state Parents As Teachers (PAT) office. Workgroup members include representatives from statewide organizations affiliated with the evidence-based home visiting models; state and local program staff; and individuals with expertise in training for public health nursing, early childhood and family support, child abuse prevention, AODA and mental health. The work group is charged with developing recommendations for a robust home visiting training and technical assistance system, including strategies for helping existing programs transition to evidence-based models.

DCF, DHS and its partners took advantage of the state plan development process to review and make recommendations for improvements to the existing system for home visiting in Wisconsin, largely through the ECAC Ad Hoc Committee on Home Visiting work groups. The Training and Technical Assistance work group reviewed the framework for home visitor and parent education

training based on the *Wisconsin Core Competencies in the Field of Family Support* adopted in 2004 and competency maps for the Michigan Infant Mental Health Endorsement (IMH-E) process that has recently been implemented in Wisconsin. Currently, fourteen states have implemented the Michigan IMH competencies and endorsement process, and several other states and countries in Europe and Asia are also considering adoption. These competencies will be added to the core training for home visitors. In addition to intentionally weaving in cultural competency themes/strategies into all training, the work group identified the following gaps in current training and training priorities for 2011:

1. Updating *Home Visitation Foundations*[1] curriculum to include the following:
   - Introduction of family teaming and motivational interviewing concepts and techniques (to be followed by more intensive skill development training as the home visitor gains more experience)
   - More in-depth discussion of setting/maintaining boundaries and working with families in an ethical way
   - Developing transition plans for families "graduating" and/or transitioning to another early childhood or family support program
   - Deeper discussion about how to effectively use reflective supervision to improve practice
2. Development of a "Home Visiting 201" for more experienced home visitors
3. Enhancing training and supports specifically for home visiting program supervisors
4. Enhancing training and technical assistance regarding data collection, program evaluation and CQI efforts

In addition, the ECAC Ad Hoc Home Visiting Committee recommended a more intentional focus on strategies for working with hard to reach families (i.e., parent engagement) and more robust information about the prevention of child abuse and neglect. The Committee also emphasized the need to develop effective strategies for helping existing home visiting programs (non-MIECHV funded) transition to evidence-based models. The new system will continue to support local peer networks of front-line staff and supervisors through information sharing and lessons learned via the CoPs. The final component of Wisconsin's training and technical assistance system is participatory evaluation to determine the effectiveness of these efforts.

<u>Developing In-State Training Capacity for HFA</u>

Currently, the *Home Visitation Foundations* meets the requirements for introductory home visitor training for the Early Head Start, PAT and HFA models. However, accredited Wisconsin HFA sites must send their assessment workers outside of the state for this required training with the associated costs. In addition, HFA requires staff to receive particular issue-based training, most of which are modules available on their web-based system and are included as part of the affiliation and accreditation fees. HFA is currently reviewing their affiliation/accreditation process, which may change the introductory home visiting training requirements. Given the number of sites that have committed to seek affiliation and eventual accreditation and the

[1] The Foundations training targets new home visitors. It is based on the *12 Critical Elements of Successful Home Visiting* using strength-based practice approaches and child and family development principles. Training also includes an introduction to reflective practice, connecting families to community resources, goal setting, boundary setting, personal safety and the importance of documentation.

possible restructuring of the HFA training and accreditation processes, the State will contract with the national office to develop in-state HFA training capacity.

As articulated by HFA staff, states are best supported when building on state strengths. Particularly, as it relates to the functional areas of training, technical assistance and quality assurance, they found that emerging HFA state systems have often benefited by drawing on existing expertise within the state, and utilizing HFA leadership from well-established HFA sites to help mentor new sites. In addition to the peer-to-peer support, a mentor site can lend valuable guidance to the state regarding functional requirements in additional areas like policy to guide operations and evaluation to inform service delivery across sites. This is consistent with Wisconsin's proposal to augment the training and TA system by developing a Home Visiting Mentor-Protégé Program, and supports the plan to use Brown County's HFA program as a pilot HFA mentor site.

Implementing Wisconsin's Home Visiting Community of Practice

As a complement to the home visiting training and technical assistance activities, Wisconsin envisions establishing three communities of practice. In the Milwaukee area, the State will build on the *Maternal & Child Home Visitation Community of Practice* supported by Project LAUNCH with the intention to engage home visiting practitioners – at the direct service and supervisor/administrator levels – to improve the way they work together, including sharing resources/tools, making referrals, implementing best practice standards, and keeping informed about one another's programs. Two additional CoP - one in the Fox Valley and one specifically for programs that serve tribal communities - will be developed over the next two years, in partnership with the funded and non-MIECHV-funded home visiting programs, professional development providers, and DHS and DCF regional staff.

To enhance the developing Milwaukee CoP, grant funds will be used to support an independent organization to organize and facilitate the meetings. Staff at MHD believes that having an independent organization as convener of the MCH CoP will help promote ownership among participating home visiting programs.

DCF and its partners have identified the Fox Valley as the likely location for an additional regional CoP, and all area programs – whether or not they receive state and federal funds – would be invited to participate. The newly funded Northwoods Program staff would also be invited to attend the Fox Valley CoP so that they may benefit from the opportunity to learn from and network with other home visiting programs as they start up their multi-county HFA site. Finally, DCF proposes to develop a CoP for the programs that serve tribal communities, recognizing that those evidence-based home visiting programs will be integrated into existing complex early childhood and family support services systems of the tribes involved and will work with tribal families that may require specific culturally relevant services.

For each CoP, the aim is to move away from a single event – such as an annual meeting or conference – to a year-round strategy for participants to regularly exchange ideas and learn from one another. The CoP will involve quarterly meetings, though work groups that are tackling a particular issue – i.e., developing centralized intake systems, engaging immigrant communities, using data in decision-making or engaging hard to reach families – may meet more often.

Wisconsin proposes to also use web-based technology to create a virtual CoP so that members can communicate more easily and efficiently – and problems can be quickly addressed.

Implementation of the Home Visiting Mentor-Protégé Program

At this point, as opposed to simply rolling out a statewide home visiting mentor program, the State is electing to create two pilot "matches" for the proposed *Home Visiting Mentor-Protégé Program*. State staff and the evaluators will engage the pilot sties in participatory research as a means to inform the process for most effectively matching the mentors and protégés, to further refine how mentor and protégé sites are identified and assessed for participation in the program, and to determine what types of technical supports state staff and the model developers may need to provide to ensure successful matches. As currently defined, Home Visiting Mentor sites are experienced programs that have been accredited by the national evidence-based model for at least a year and are willing to commit time to help new/transitioning programs reach their potential. Home Visiting Protégé sites, on the other hand, are new/transitioning programs that are willing to commit time to work with mentors to improve their capacity to provide high quality home visiting services that will eventually lead to accreditation from the national evidence-based model.

Given the significant interest in developing Healthy Families America (HFA) programs, Wisconsin is proposing to pilot the *Home Visiting Mentor-Protégé Program* with Brown County as an HFA mentor and Rock County and the Northwoods Project (Lincoln/Oneida/Forest) as protégé sites. These organizations will assist state staff in developing the Mentor-Protégé Program by providing regular feedback through the participatory research component to increase the program's effectiveness and, as importantly, document the process. The State is proposing to pilot the Brown County HFA program as its first mentor site because the program has a long history of HFA model fidelity. This program could be a tremendous asset as we develop in-state capacity to deliver and expand HFA services. The two proposed protégé sites – the Northwoods Program and the Rock County site - are also willing to participate in the pilot of the Home Visiting Mentor-Protégé Program, considering their participation in the mentor program as a critical feature of a successful HFA program start-up.

Operationalizing the Home Visiting Mentor-Protégé Program

One of the principle goals of the pilot program is to develop a process to effectively match experienced programs with less-experienced ones. The role of state staff in supporting this peer relationship is critical to making the mentor-protégé relationship useful and meaningful for both parties. For example, the State will play some role in "accepting" applications for mentor and protégé sites, approving matches, and regularly reviewing progress. This will be an iterative process, with state and program staff "learning by doing", regularly reflecting on what is working, what needs to be altered to work more effectively and how what is being learned can be translated into processes and practices for subsequent matches in the future. A mentor-protégé protocol and handbook will be developed based on the experiences of the pilot mentors and protégés as well as the research findings.

Plan for staffing and subcontracting

Both the HVC and the Nurse HV Consultant will have responsibilities to provide support and technical assistance to programs enhancing or expanding their evidence-based home visiting programs, to work with the ECAC Home Visiting Training/TA work group to further develop the state's training/TA system, and to assist with the development of the practice innovations - the home visiting *Communities of Practice* and *Mentor-Protégé Programs*. The HVC will serve as the liaison to the evaluators and training contractors for this two-year demonstration project. The Home Visiting Performance Planner will provide support and technical assistance related to data collection and reporting for all sites added with the MIECHV development grant funds. S/he will also assist in monitoring model fidelity.

Subcontracting with UW-Milwaukee

UW-Milwaukee researchers from the Helen Bader School of Social Work will oversee the implementation of the Evaluation Plan described in subsequent sections of this proposal.

Subcontracting Project Management for Training/TA

As recommended by the training and technical assistance work group, the State is considering contracting with an outside vendor for the management and coordination of home visiting training and technical assistance. Currently, the State contracts with the UW-Madison Extension and Milwaukee Extension for these services. For this demonstration project, the State will contract with the Milwaukee Extension to assist with development and implementation of the tribal programs and Fox Valley regional Communities of Practice (Cop). Contract duties may include: coordinating meeting logistics, developing meeting agendas, conducting a needs assessment among participating organizations/staff to help identify relevant CoP discussion topics, and working with the Project Team to identify and invite guests and content experts to participate in appropriate CoP discussions. Responsibilities may also include conducting follow-up with participants to ensure the groups are meeting their needs and assisting in the evaluation of the training and TA system, including evaluation of the Mentor/Protégé program and CoP.

Recruiting and Retaining Participants in Home Visiting Programs

Based on the experience of existing home visiting programs as well as other initiatives brochures, flyers, posters, newspaper articles, radio shows, public service announcements, informational videos, social media, health fairs, presentations to community organizations, home visiting staff embedded health care clinics, incentives provided for participation, parent ambassadors, and community baby showers have all been successful means to recruit and retain participants in the home visiting programs. Engagement of fathers with programming specific to their needs was included in response of each site to the Request for Proposals.

Continuous Quality Improvement (CQI) Plan

Newly funded programs will benefit from the strong infrastructure to support Continuous Quality Improvement (CQI) efforts at the state and local levels described in the Updated State Plan, including the following key elements:

1. Ongoing assistance from the Home Visiting Evaluation and Program Improvement Work Group, in consultation with local program staff and other stakeholders, including:
    - Identification of priority outcomes based on community and state needs and goals

- Development of benchmark targets for these priority outcomes

2. Development of a home visiting "dashboard," as recommended in federal CQI TA calls
3. Ongoing enhancement of the SPHERE data system
4. Development of *Regional Communities of Practice* to share best practices
5. Partnership with *The Early Years Home Visitation Outcomes Project of Wisconsin* to assist home visiting programs to collect clean data and use that data to inform CQI efforts
6. State leadership in dissemination of CQI research and best practices
7. Participation as a pilot site for the Pew Center on the States' home visiting quality assessment tool project

Contract oversight and training/technical assistance around CQI will be the primary responsibilities of the Home Visiting Performance Planner, in concert with the Home Visiting Coordinator. In addition, via the RFP process, programs were asked to develop individualized CQI plans, including dedicated staff and regular reporting. As in the Updated State Plan, a semi-annual review of Development Grant funded programs' CQI plans will be a critical element of the contract monitoring process.

Plan to maintain fidelity to model

Wisconsin has received approval from the national Head Start offices in ACF to partner with them in the implementation of Early Head Start home based option in Wisconsin. State Home Visiting staff will continue to work with the national Head Start trainers through STGi located in Madison to guide the implementation of any newly funded EHS program as a result of receiving this Development grant. Additionally, the Home Visiting Performance Planner will work with ACF Head Start staff to ensure that data collection and reporting requirements for both the State and the national Head Start Office are met.

Wisconsin has been approved to implement Healthy Families America (HFA) home visiting programs in the State using MIECHV funds. Most of the sites funded through the addition of the Development grant funds are implementing the HFA model. Given a clear interest in HFA in Wisconsin, DCF and DHS will engage with HFA staff and trainers to ensure that existing and new models implement the programs with fidelity and are well-supported to meet the affiliation and eventually, the accreditation standards. With the added dollars of the Development grant, DCF plans to develop a capacity for "train the trainers" model to build state infrastructure for future expansion of HFA programs in the coming years.

For this proposal, Wisconsin also received approval from the national office to implement PAT programs using MIECHV funds. The State is committed to working with the PAT national as well as Parents Plus, the State's PAT office to implement quality programs that meet PAT standards as part of the Wisconsin Home Visiting Program. DCF and DHS will continue to partner with Parents Plus through training, technical assistance and on-going systems development.

Plan to collect data on legislatively-mandated benchmarks

One of the primary goals of Wisconsin's Development Grant application is to support the development of a statewide home visiting program. To this end, Wisconsin will require newly funded programs to comply with the general benchmark data collection plan guided by the SIR

and outlined in the State Plan (pending approval from the federal government). This plan requires all MIECHV funded programs to collect data on all constructs, for all service recipients (as appropriate) when the family is enrolled in the program and one year post-program (or as dictated by future federal guidance). Improvement over time will be measured per the State Plan and subsequent federal guidance. Newly funded programs will also be required to use the standardized instruments identified in the Updated State Plan: SPHERE questionnaires, Ages and Stages Questionnaire 3 (ASQ-3), Ages and Stages Questionnaire: Socio-Emotional (ASQ: SE), The Home Observation for Measurement of the Environment (HOME), Edinburgh Postnatal Depression Scale (EPDS), and the Perceived Stress Scale (PSS). See Project Evaluation Plan for more information about instruments and supplemental measures.

Benchmark data will be collected primarily via the *Secure Public Health Electronic Record Environment (SPHERE)* public health data system. With federal support, Wisconsin implemented SPHERE in 2003 to enhance monitoring, evaluation, and coordination of health-related services. Since then the system has become a critical tool for the delivery of public health services in the state. For some maltreatment constructs, we will also use *The Wisconsin Statewide Automated Child Welfare Information System (WiSACWIS)*, the administrative database used by the DCF Division of Safety and Permanence (DSP) to track child welfare services and outcomes. With assistance from DCF staff in the Bureau of Information Technology Services (BITS), information from this database will be matched with home visiting program participation data to track reported suspected and substantiated maltreatment outcomes. The State will continue to explore the potential use of Medicaid data and data regarding families' collection of public benefits and child support to compliment current data collection.

Indicators for each construct, listed below, were developed by the Home Visiting Evaluation and Program Quality Work Group, using the general principles from the SMART (Specific, Measureable, Attainable, Relevant and Timely) goal system recommended in the May 2011 DOHVE Measurement Brief, "Selecting Data Collection Measures for MIECHV Benchmarks." Group members attempted to leverage existing data collection practices and data structures, while also taking advantage of opportunities for meaningful system and measurement improvement. In addition, the group considered existing reporting needs under WI State Statute Chapter 48.983, the legislation that authorizes and provides authority to DCF related to the distribution of home visiting grants via a competitive process.

<u>Improved Maternal & Newborn Health</u>

- *Prenatal Care*: % pregnant women served receiving prenatal care in the 1st trimester
- *Parental Use of Alcohol, Tobacco, or Drugs*: % women served using tobacco after birth
- *Preconception Care*: % women served taking a supplement that contains folic acid
- *Inter-Birth Intervals:* % women served who receive information about birth spacing
- *Screening for Maternal Depressive Symptoms:* % of postpartum women served who are screened for depression postpartum using a standardized tool
- *Breastfeeding*: % women served who breastfeed for 3 months or more
- *Maternal and Child Health Insurance Status*: % women and children served with any type of health insurance
- *Well-Child Visits:* % children served with appropriate number of well-visit health exams

<u>Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency</u>

- *Visits to the ER Department from All Causes*: Rate of ER visits for children served

- *Visits for Mothers to ER Department, All Causes*: Rate of ER visits for mothers served
- *Information or Training Provided to Families on Prevention of Child Injuries*: % women served who receive information or training on injury prevention
- *Incidence of Child Injuries Requiring Medical Treatment*: Rate of ER visits for physical injuries, by children served
- *Reported Suspected Maltreatment for Children in the Program (screened in but not substantiated):* % children served with a screened in report of suspected maltreatment (As possible, measure will be reported in aggregate, and also for each of the following: neglect, physical abuse, sexual abuse, emotional abuse, other maltreatment)
- *Reported Substantiated Maltreatment for Children in the Program (substantiated/ indicated/alternative response victim)*: %children served with at least 1 reported, substantiated instance of maltreatment (As possible, measure will be reported in aggregate, and also for categories listed above)
- *First-time Victims of Maltreatment for Children in the Program:* % children served who are first time victims of maltreatment, to be determined using a standardized questionnaire or tool (As possible, measure will be reported in aggregate, and also for categories listed above)

Improvements in School Readiness and Achievement

- *Parent Support for Children's Learning and Development (e.g., having appropriate toys available, talking and reading with their child):* % enrolled families whose total HOME score improves between the 6- and 12-month assessment
- *Parent Knowledge of Child Development and Their Child's Developmental Progress:* % mothers served who receive information or training on child growth and development
- *Parenting Behaviors and Parent-Child Relationship*: % newly enrolled families whose total HOME score improves between the 6- and 12-month assessment
- *Parental Emotional Well-being or Parenting Stress*: % newly enrolled mothers administered the *Perceived Stress Scale* within the first month of enrollment
- *Child's Communication, Language and Emergent Literacy*: % children who received services within 2 months, whose most recent ASQ-3 score (communication domain) indicates a potential concern
- *Child's General Cognitive Skills*: % children who received services within 2 months, whose most recent ASQ-3 score indicates a potential concern
- *Child's Positive Approaches to Learning Including Attention*: % children who received services within 2 months, whose most recent ASQ-3 score (problem solving domain) indicates a potential concern
- *Child's Social Behavior, Emotion Regulation, and Emotional Well-being*: % children who received services within 2 months, whose most recent ASQ-SE score indicates a potential concern
- *Child's Physical Health and Development*: % infants served born weighing < 2,500g

Domestic Violence

- *Screening for Domestic Violence*: % families served who are screened for domestic violence using a standardized tool or questionnaire
- *Of Families Identified for Presence of Domestic Violence, Number of Referrals Made to Relevant Services*: % families who received a referral for services after being identified for presence of domestic violence

- *Of Families Identified for Presence of Domestic Violence, Number of Families for which a Safety Plan Was Completed*: % families who received services after being identified for presence of domestic violence

Family Economic Self-Sufficiency

- *Household Income and Benefits*: % families served who report an increase in total household income and benefits
- *Employment of Adult Members of the Household*: % households served with at least 1 employed adult within the last quarter
- *Education of Adult Members of the Household*: % mothers served who report an increase in educational attainment
- *Health Insurance Status:* % mothers and fathers with public or private health insurance

Coordination and Referrals for Other Community Resources and Reports

- *Number of Families Identified for Necessary Services*: % of postpartum women served who are screened for depression postpartum using a standardized tool
- *Number of Families That Required Services and Received a Referral to Available Community Resources*: % mothers who received a referral for services after being identified for potential presence of postpartum depression
- *Number of Memoranda of Understanding or Other Formal Agreements with Other Social Service Agencies in the Community*: Total number of Memoranda of Understanding or other formal agreements with other social service agencies in the community
- *Number of Agencies with which the Home Visiting Provider has a Clear Point of Contact in the Collaborating Community Agency that Includes Regular Sharing of Information between Agencies*: Total number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies
- *Number of Completed Referrals*: % mothers who received services after being referred, due to identification for potential presence of postpartum depression

Each program will be responsible for collecting its own data and recording information in SPHERE. In addition to providing a format for collecting required data, SPHERE allows users to access longitudinal client and program-level data for CQI purposes. At the State level, the Home Visiting Performance Planner will have the primary responsibility for overseeing data collection and analysis. The Planner's work will be supported by a research analyst at DCF, the State Systems Development Initiative Coordinator for the DHS/MCH Program, SPHERE staff at DHS, as well as the Evaluation and Program Improvement Work Group. The Evaluation and Program Improvement Work Group has also recommended that the State partner with the *Early Years Home Visitation Outcomes Project of Wisconsin* to support training and quality assurance for the implementation of required standardized tools.

In addition, members of the Home Visiting Project Team continue to work with other agencies and stakeholders on the development of a State *Early Childhood Longitudinal Data System*. This system, in the early discussion stage of planning, will connect information about children, families, and programs across service sectors, in order to better answer important policy questions such as which children have access to which services, and which characteristics of intervention programs are associated with positive outcomes for families.

Plan to coordinate with appropriate entities/programs

Assets and partnerships to address Wisconsin's identified needs and foster the potential to develop high quality, evidence-based home visiting programs in the state with expansion to additional sites include the following:

Maternal and Child Health Program Early Childhood Systems Initiative: Under the leadership of Wisconsin's Title V MCH Program, local health departments were asked to focus resources in 2011 on establishing a coordinated, integrated and sustainable system of prevention services and promotion of health for families. Focus areas for systems building work include using the life course framework in providing family supports, mental health, child development, and safety and injury prevention programs.

Project LAUNCH: The Project LAUNCH initiative was built upon the work of the Early Comprehensive Childhood Systems (ECCS) grant with a primary focus on the City of Milwaukee. Five prevention programs, including evidence-based home visiting, are provided within high risk neighborhoods under the leadership of the Milwaukee Health Department.

Early Comprehensive Childhood Systems (ECCS) grant: The ECCS program focuses on developing a cross-system comprehensive early childhood system addressing the following five components: family support, parent education, access to health and medical home early care and education, and mental health and social and emotional development. By linking with the Early Childhood Collaborating Partners (WECCP), ECCS has fostered development of the Infant Mental Health Endorsement system adapted from Michigan.

Milwaukee Community Response Program: The Wisconsin Children's Trust Fund, the DCF, and researchers at the University of Wisconsin-Madison have developed the Milwaukee Community Response Program to assist families at risk for child maltreatment in accessing economic resources and reducing financial stressors in order to prevent child abuse and neglect. Families that are reported to child protective services (CPS) but screened out following an initial assessment will be eligible for these services.

Place-Based Initiatives: The Wisconsin Children's Trust Fund will release a request for proposals (RFP) in late August to support an initiative in a county (ies) identified as high-risk for child maltreatment that will utilize the Durham Family Initiative model. The Durham Family Initiative is designed to help families at risk of child abuse become self-sufficient and supportive of their children's health, growth and development; help stressed neighborhoods become supportive environments for children and families; help the community support families and neighborhoods; and help public and private service organizations integrate their services so they can most effectively promote child well-being and prevent child abuse.

The Early Years Home Visitation Outcomes Project of Wisconsin is a collaborative effort under the leadership of the Child Abuse Prevention Fund of Milwaukee Children's Hospital and Health System with ten home visiting providers, public and private funders, and an evaluator to provide an outcome measurement framework for Wisconsin's home visiting programs. With that framework, the programs collect identical data in SPHERE which in turn is used for program improvement and cross-model outcome measurement reporting. Each of the participating

programs uses common screening tools (ASQ, ASQ Social Emotional, HOME Inventory, DPH Home Safety Assessment. Their experiences will inform our work to better implement effective, quality home visiting program services.

Description of how the proposed activities would fit into the state administrative structure
Wisconsin has developed and will further develop and monitor the implementation and integration of additional Wisconsin evidence-home visiting programs that will meet the overall goals and objectives of the approved home visiting state plan. The State is committed to coordinate the additional programs within the following administrative structure:

- Engagement of home visiting programs and public and private stakeholders in the implementation and continuous quality improvement of the Wisconsin Home Visiting initiative;
- Support of the professional development of home visitors and supervisors;
- Monitor the implementation, continuous quality improvement and fidelity to the chosen model; and
- Enhancement if the State administrative structures to support comprehensive evidence-based home visiting services in the at-risk communities.

Plan to ensure incorporation of project goals, objectives, and activities into the ongoing work of the eligible applicant and any other partners at the end of the federal grant
The Wisconsin Home Visiting planning process has fostered broad based public and private interest and support. Many public and private agencies have come together with a common goal of implementing strong foundation structures to support implementation of evidence-based home visiting programs in at-risk communities while fostering overall quality improvement of home visiting services throughout Wisconsin. Challenges to full implementation and sustainability of the Home Visiting Development grant funds reside within the fiscal decline of available state revenues. However, the State home visiting leaders are committed to building and sustaining the programs and system through strategic review, realignment, and innovative activities.

Under the leadership of the State Home Visiting Program Staff and as directed by the ECAC, a review of existing state funding for home visiting will be done with an eye to direct it to proven home visiting program services. Funds that may be opportunities for realignment to support evidence-home visiting include Safe and Stable Families and Brighter Futures funds under management of DCF. Also the State MCH program is supporting local health departments to foster development of strong, local early childhood efforts to better improve population-based outcomes for maternal and child health populations. Local communities initiating home visiting programs may decide to direct some of their MCH allocations to support continuing their home visiting programs. In addition, Wisconsin Medicaid program has provided some support through case management programs for women and children at risk of adverse pregnancy or other health outcomes. Optimizing local capacity to receive reimbursement from the Wisconsin Medicaid Prenatal Care Coordination, Child Care Coordination and Targeted Case Management for children at risk programs will support in part continuing home visiting programs and services in the state.

In the Request for Proposal process, proposers were required to develop sustainability plans for continuing the programs once the grant period ends. The plans will involve marketing strategies

not only to encourage program participation but also to motivate potential private donors to support them financially. As part of their CQI processes, sites have proposed to conduct annual self-assessments to identify challenges and develop appropriate plans of action to overcome those challenges, including issues related to funding and building support in their communities. By using CQI, programs will engage in results oriented evaluations, analyzing their performance and making decisions based on solid data collected, which in turn, will help to demonstrate their program's effectiveness to policy makers and potential donors. In addition, through formal training, the *Communities of Practice* and the *Mentor-Protégé Program,* the State will provide programs opportunities to further develop their sustainability action plans over the next two years. In recognition of the need to plan for sustainability as a critical part of program implementation, the work group will be focusing attention on developing tools and workshops to help programs increase revenue through MA billing and create meaningful partnerships with area policy-makers, businesses, and philanthropists. The ultimate goal will be to ensure that each evidence-based home visiting program funded through state and federal funds is a permanent part of the community resources.

RESOLUTION OF CHALLENGES

Working with Difficult to Engage Populations

For some of the programs that are new or implementing a new model, targeting families that have multiple risks and may be involved in multiple systems may present added challenges. Special attention will be paid to this issue in training and will be an on-going topic for discussion at *Communities of Practices*.

Challenges with Communities of Practice: Parental Engagement

The most difficult component of CoP may be engaging participating families. Disadvantaged families face a host of obstacles to participating in groups, especially those focused on governance or policy. These obstacles include practical issues such as time, child care and transportation plus intrinsic issues such as feelings of insecurity, feeling capable to having anything to contribute and feeling unwelcome. (Baker, et al, 2001) Head Start offers valuable experience in how to overcome these barriers and successfully engage parents in improving services. Most importantly, research suggests that engaged parents have a positive impact on early child development and school readiness. (Marcon, 1999)

To the extent possible, the State envisions having at least three parents who are/were home visiting participants join a CoP by the end of year one. Program families bring a wealth of knowledge and information to discussions about how best to meet their needs, but are often excluded from any meaningful discussions. Toward that end, Development Grant funds are being set aside to identify and/or develop effective strategies for helping parents play a vital role in designing effective practices to help them meet their goals. For example, the Project Team will explore the feasibility of implementing a Parent Leadership Training Institute (PLTI) to facilitate parent engagement in the CoP. Developed by the Connecticut Commission on Children and used by numerous states, PLTI has been extremely successful in giving parents the tools and skills they need to be effective advocates for themselves and their communities.

Challenges with Benchmark Reporting

- While Wisconsin will greatly benefit from the fact that it already has an established database that can be used by home visiting programs, we know that for programs new to SPHERE, training and technical assistance will be needed. The State will work closely with these new programs, and will encourage peer learning exchanges between seasoned SPHERE users and new staff. The SPHERE workgroup, which will include state and local staff, will identify needed enhancements to the system, to support meaningful data analysis and CQI efforts.
- We remain concerned about burdens related to programs' needs to comply with what may amount to different data collection requirements for both the MIECHV grant and the national models. The State's goal is to work collaboratively with the Early Head Start and HFA model developers to ensure that their requirements for data collection are met while double entry of data or use of multiple tools to measure the required constructs is minimized for the sites where possible.
- Implementing a mix of home visiting models presents a particular series of challenges for the State. While the SIR requires states to report all benchmark data aggregated at the state level, models and programs have been developed to impact outcomes in different benchmark areas, and communities were encouraged to choose models based on their demonstrated ability to address specific community needs and populations. Thus, we remain concerned about the potential "dilution" of individual program success due to this aggregate reporting requirement. We hope to receive additional technical assistance on how to deal this issue throughout the reporting process.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

Home Visiting State Staff

The DCF Home Visiting Coordinator (HVC) is funded through the Wisconsin TANF block grant. The HVC will lead the Project Team meetings, staff the ECAC Ad Hoc Committee on Home Visiting and its workgroups, and oversee the implementation of the home visiting programs throughout the state. Two proposed State positions to support the day to day work to implement the Home Visiting State Plan are planned for hiring by fall 2011 and include:

- *Home Visiting Performance Planner*- assists in program monitoring related to data collection and reporting and provide leadership in the state and local continuous quality improvement efforts. The hiring process for the Performance Planner has been initiated and it is anticipated the position will be filled by August 2011.
- *MCH Home Visiting Nurse Consultant* - assists the HVC with management of the day to day implementation of the home visitation grant and provides leadership to assure connection to the Title V MCH Program. The hiring process for position has been initiated and is anticipated to be filled this summer.

DCF and DHS have successfully managed implementation grants from federal agencies including DHHS.

Project Evaluation Plan

Introduction. An independent evaluation of Development Grant activities will be conducted by University of Wisconsin-Milwaukee (UW-M) researchers who are neither employed by nor receive any compensation from the agencies that comprise this initiative.

Although clients who receive home visitation services often benefit measurably, the effects of such programs are highly variable. Even for evidence-based programs such as HFA, EHS, and PAT null findings are normative and significant impacts often come in the form of small effect sizes. A central explanation for these mixed findings relates to variation in service quality. For instance, program effects may be enhanced if services are delivered with greater intensity, for a longer duration, and by professionals employing a standardized curriculum. Home visitation programs that provide high-quality services with fidelity to an evidence-based model tend to perform well in empirical trials, but these kinds of programs are in the minority (Gomby, 2005). Moreover, programs documented as efficacious often struggle to replicate comparable effects when they are taken to scale in real-world contexts (Daro, Dodge, Weiss, & Zigler, 2009).

Acknowledging the above challenges, the proposed project is designed to initiate a process that guides home visitation programs statewide toward adopting evidence-based practices that translate effectively into community settings; in particular, to improve child and family outcomes in the three focal benchmark areas of this project: (a) maternal and child health, (b) reduced child abuse and neglect, and (c) school readiness. According to Webster-Stratton and Herman (2010), "doing so requires organizational commitment to train dedicated staff and to create an infrastructure for providing timely training, skillful supervision and mentoring, adequate resources, and ongoing process and outcome evaluations." Each of these requisite components is reflected in the project's theory of change, as illustrated by the attached logic model (Attachment 1). In addition to increased funding for program services, the project will create supports through Communities of Practice (CoPs) and an agency mentorship protocol. By linking home visitation programs together and with other relevant agencies and service systems, the CoPs are designed to advance a fourth benchmark goal: coordination and referrals for other community resources and supports. Like the CoPs, partnering less developed home visitation sites with more mature mentor programs is expected to promote model fidelity and continuous quality improvement. Altogether, this infusion of resources within an integrated system is expected to promote the long-term goals of enhanced client outcomes.

With the above objectives in mind, the proposed evaluation will gather qualitative and quantitative data longitudinally from various stakeholder groups. Along with analysis of aggregate project data, we will assess the performance of individual project sites to account for distinct differences in both program characteristics and intervention responses. Coupled with the aim of assessing individual, family, and agency change, the evaluation is designed to disseminate information repeatedly back to program sites to stimulate program development. In this way the evaluation is both summative and formative—it aims to examine progress toward articulated goals while simultaneously promoting program development toward achieving these goals. In sum, we take a developmental approach to evaluation, one that is congruent with the intent of this development grant. This evaluation will yield useful information toward the immediate goals of this project as well as the ultimate goals of a future expansion grant dedicated to scaling up evidence-based home visitation practices in Wisconsin.

Sample. Five program sites will participate in the evaluation, including two community agency sites in Milwaukee County (Next Door Foundation and Aurora Family Services/Rosalie Manor/Parenting Network) and three public agency sites in other regions of the state (the Great Lakes Intertribal Council, i.e.,GLITC, Rock County, and Brown County). The project sites will serve catchment areas characterized by high rates of poverty, single parenthood, teen pregnancy, and other environmental and demographic risk associated with poor birth outcomes, compromised maternal and child health, child developmental delays, and child maltreatment.

Over the course of the 2-year study period, administrators anticipate that the 5 sites will serve approximately 800 families: 300 in year 1 and 500 in year 2. The sample will increase between years 1 and 2, because sites will expand outreach and service capacity. Service providers (e.g., family visitors), supervisors, and administrators will be sampled from each site to participate in focus groups. We will also rely on program site staff to recruit eight parents, either alumni of the program or current service recipients, for client focus group meetings.

Design. A randomized experiment is neither feasible for this project nor well-aligned with its designated aims. Based on careful consideration of quasi-experimental alternatives, we will assess change in benchmark indicators using an interrupted time-series design. This approach achieves the best fit between methodological rigor, the proposed multi-site intervention protocol, and the articulated goal of using evaluation findings to foster CQI.

Data gathered from each of the five selected home visitation sites will be used to construct measures at equally spaced time intervals. We anticipate measuring indicators monthly, though power analyses may reveal that more frequent observations are warranted. Two of the sites (Brown Co.; GLITC) already report data that are recorded in existing administrative databases (see Data Collection Procedures). For these sites we will gather data throughout the project period along with archival data for two years prior to the project start date. Analyzing repeated measures pre- and post-intervention will increase our capacity to separate change associated with the intervention from other spurious influences. Moving forward, the remaining three sites in Milwaukee and Rock Counties will be required to collect data needed to capture all required indicators. To the extent possible, other data that have been collected and stored locally will be used to construct time-series observations for these sites prior to the project start.

Interrupted time-series designs have several noteworthy strengths that will enhance statistical inferences. Time-series data can be used to estimate whether observed changes are attributable to an intervention without the benefit of a comparison group (Rossi, Freeman, & Lipsey, 1999), and they are especially well-suited for examining systems-level change (West, Biesanz, & Pitts, 2000). It is also possible to use time-series data to forecast expected future trends. Methodologists recognize the scientific merits of time-series designs, including the potential to estimate effect sizes at multiple time points. To the extent data are stationary and stable prior to the intervention, time-series data also can generate sufficient statistical power with modest sample sizes (McLeod & Vingilis, 2005). This design often has practical appeal to local providers as well, because it does not require treatment manipulation and can build on existing data structures. Time-series data can be used descriptively to portray trends reflected in sequential observations; these data can be depicted graphically in an intuitive way that is interpretable to a lay audience, thereby enhancing the dissemination of findings.

Time-series designs are not without limitations, however. They minimize some internal validity threats (e.g., regression to the mean; testing), but they cannot adequately address others. A significant limitation of this design is that it cannot rule out unexplained sources of variance that might otherwise explain estimated effects. Certain analytic approaches (e.g., ARIMA) employed with time-series data can be undermined by non-stationary data and when there are a limited number of data points (Box & Jenkins, 1976; Yaffee & McGee, 2000). Therefore, due caution will be exercised when interpreting the descriptive and predictive value of findings.

Conclusions drawn from quantitative analyses will be strengthened by analyses of process data collected from three constituent groups: clients, program service providers, and program supervisors and administrators. We will utilize a community-based participatory action research model, which will help to identify and purposefully select participants (stakeholders).

We will also utilize focus groups, one during early stages of the project (months 4-6) and a second in latter stages of the project (months 16-18), to ascertain stakeholder knowledge and experience. Distinct from data produced through individual interviewing and observation, the data collected through focus groups will yield rich and complex interpretive insights into communal knowledge and practice (Denzin & Lincoln, 2005).

Qualitative research has its own limitations, including limited generalizability across distinct populations and settings, potential influence of researcher bias, as well as a requisite investment of considerable resources. Nevertheless, adopting a rigorous, participatory approach to evaluation will enhance the project in several ways. Qualitative data can be used to catalogue participant perceptions and meaning in a way unlikely to be captured by quantitative data. A level of detail can be derived from qualitative data that is unmatched by quantitative analyses, which can be used to reflect, inform, and respond to practices in local contexts. Focus groups will help to describe individual case information and generate themes that emerge between and within stakeholder groups for comparative analysis. Data collected early in the project will lend to CQI at each site. Information gleaned from interviews will also be used to improve future data collection within the scope of this evaluation and in a future expansion grant project.

Data Collection Procedures. As indicated in our "Plan to Collect Data on Legislatively-Mandated Benchmarks," client and agency information from home visitation programs will be entered into SPHERE, and we will use this data to measure individual, family, community and agency indicators that reflect programming goals and client outcomes. We will also collect information regarding documented incidents of child maltreatment from WiSACWIS. Public Health records of health insurance receipt.

Despite the breadth of available data in SPHERE and WISACWIS, the current capacity to assess some indicators of client and program functioning in depth is limited. Bridging these gaps could enhance service coordination, evaluation efforts, and program delivery. Thus, we will gather survey data to augment administrative data. We have selected self-report or observational assessments that are widely used and psychometrically sound. Careful to avoid overburdening clients or providers, we have selected brief survey instruments that can be measured within a single home visit. Furthermore, home visitors will collect qualitative data from service recipients who respond to several open-ended questions. Focus groups with key stakeholders, including clients, will generate additional qualitative data. Finally, we will also gather implementation fidelity and cost data from local program sites. This diverse range of information will guide program improvements and strengthen program performance from multiple perspectives.

.Administrative and Survey Data. At project outset, we will collect pre-intervention data from two program sites (Brown Co, GLITC), both of which record client demographic and assessment data as well as agency information in SPHERE (see Data Management section). Multiple data points extending two years prior to the project start date will help establish pre-intervention trends. We will also explore the local records of the three remaining project sites to determine the feasibility of collecting comparable pre-intervention data.

Upon project commencement, all five project sites will be required to enter client and agency level data into SPHERE. At present, programs conduct initial and ongoing assessments at regular intervals according to model guidelines. After receiving training, sites will administer parent-report surveys to all participants enrolled in home visitation services. We have selected instruments (see Measures below) that will supplement extant administrative data. Beginning in project months 4-6 we will access and download site data from SPHERE, WISACWIS, and public health insurance records, and collect all completed survey information.

Data coding will ensue, per the procedures outlined in the Data Management section below. We will organize all information by multiple time points in order to develop the number of data points required for reliable time-series analyses. To clarify, although we will gather all study information at 6-month time periods, we will create shorter data intervals (i.e., monthly). One of the strengths of this design is that we can assess agency data over selected time periods without accounting for sample attrition from any one cohort (see Design section).

As the study progresses, project personnel will expand the number of fields in SPHERE in order to incorporate data from the newly introduced survey instruments. Collaboration between the evaluation team, site personnel, data managers, and state administrators in the form of a SPHERE workgroup will guide this system upgrade. Enhancing agency data collection and evaluation capacity represent significant contributions of the evaluation process.

Qualitative Data. We will gather qualitative data through several means. The newly introduced survey instruments will incorporate open-ended questions to assess the following program characteristics from the client perspective: responsiveness to family needs, effectiveness in mitigating family risk, and promotion of family strengths. In addition, we will conduct focus groups with program stakeholders, including clients, online staff, supervisors, and supervisors/administrators. Questions related to the themes of program quality and effectiveness will guide focus group discussions. The project research assistant, Colleen Janczewski, will facilitate all sessions with logistical support from a second co-facilitator, a graduate student in social work to be hired following an award notice. Both facilitators will receive training and oversight from Dr. David Pate. Proceedings will be documented with a digital recorder. Subsequently, a contracted professional will transcribe recordings.

Stakeholders from each site (and any additional sites involved in the CoPs) will participate in a total of two focus groups, the first occurring during the 4-6 month project period and the second during the 16-18 month time frame. We will convene separate meetings for a) clients, b) direct service providers, and c) supervisors and administrators, respectively. Home visitation clients will be reimbursed for their involvement at $25 per session. Each focus group will include approximately 8 participants plus the two co-facilitators. Recruitment for focus group members will happen at the site level, and actual meetings will take place at the program site or an alternative convenient location such as the meeting location for CoPs. We will allow the composition of all constituent focus groups to vary from year 1 to year 2 given the exploratory nature of this evaluation, and we will populate those meetings to the degree possible with participants who vary by age, race and length of service receipt.

Implementation Data. Implementation data will be collected in order to improve service delivery and enhance model fidelity. At the beginning of the project, meetings between personnel from the program sites and the evaluation team will help establish a plan for evaluating and strengthening program delivery. When co-developing this plan, we will draw on well-disseminated performance standards from the models represented in our project. These standards promote adherence to program principles and strategies. For instance, HFA publishes a detailed self-assessment tool that helps sites appraise their performance across a number of factors such as governance and administration, supervision, cultural competence, professional development, and family engagement. Official publications from the Early Head Start National Resource Center also inform EHS implementation quality, providing guidance in areas such as curriculum selection, engaging families, developing community partnerships, and staffing.

Because home visitation sites will differ in program features, including their model of service delivery as well as their level of institutional experience, a unique plan for evaluating

implementation quality and model fidelity will be developed for each site. Select personnel (e.g., quality improvement managers and staff supervisors) will oversee collection of local implementation data and the institution of service upgrades. Sites will share implementation data 4-6 months after the project start date and again one year later, within the 16-18 month project period. Project evaluators and site personnel will collectively review quality and content of the data along with results from data analysis. The evaluation team, in concert with site personnel, will also communicate themes reflected in the data and resulting from the analyses to the CoPs.

Cost Data. We propose collecting local cost data from each program site, including the valuation of direct and indirect costs, as well as recurring and non-recurring costs. Interviews with program administrators along with review of financial reports will produce the raw data needed to independently calculate cost estimates. We will complete these operations during the initial two months of the award period. We will also re-calculate new cost estimates with updated data in the beginning of project year 2 to capture fluctuations in program spending over time. Spending trends will be catalogued within and across sites, and these data will be used to compare local program expenditures with national norms.

All procedures involved in calculating cost data will be collaborative and transparent to promote learning and development at the local and state level. We will disseminate results via summary reports back to individual sites and in aggregate to CoPs and state-level administrators. This information will be communicated with program administrators, which may influence program delivery and enhance service provision. Last, cost estimates will yield baseline data to inform a planned expansion grant project that will incorporate cost analyses (e.g., cost-benefit analysis) as a specific aim.

***Measures*.** Guided by our research design and analysis plan, we will track program performance trends over time. To facilitate statewide, cross-program analysis and CQI, we will analyze indicators for each construct of each benchmark area as defined in our State Plan (See "Plan to Collect Data on Legislatively-Mandated Benchmarks"). In addition, if awarded a development grant, we will take the opportunity to explore additional measures, particularly for our three focal outcomes: maternal and child health, reduced child abuse and neglect, and school readiness. A supplemental discussion of quantitative measures in each benchmark area and plan for developing qualitative measures is provided below.

Maternal and Newborn Health. Eight constructs reflecting maternal and newborn health will be measured using the SPHERE database: preconception, prenatal, and postnatal care; parental use of alcohol, tobacco and drugs; depression screening; inter-birth intervals; breastfeeding; well-child visits; and health insurance coverage. For instance, providers enter data for prenatal health care visits; maternal substance use prior to conception, during pregnancy, and following childbirth; infant secondhand smoke exposure; breastfeeding; and maternal and child health insurance status. SPHERE also has a field documenting depression screening and referrals to mental health services for pregnant or post-partum women at-risk for depression. Maternal depression will be measured using the EPDS, a 10-item instrument that is widely used and psychometrically sound (Cox, Holden, & Sagovsky, 1987).

Child Injuries and Maltreatment. Assessing child injuries, child maltreatment and reduction of emergency room visits represents an evaluation priority for the project. Through SPHERE we will access data on child and mother visits to the emergency room, child injuries, and the provision of information about preventing child injury. We will also cull indicators of official child maltreatment from eWISACWIS, including reported and substantiated maltreatment, maltreatment type, and child placement status.

Official indicators of child maltreatment present well-known limitations, however. They underestimate the incidence of actual maltreatment, and they are insensitive to detecting prevention efforts due to low base rates and the countervailing effects of surveillance bias (Howard & Brooks-Gunn, 2009). Accordingly, we will augment official measures of maltreatment with several parental self-report instruments that assess actual maltreatment or risk for maltreatment, i.e., the Conflict Tactics Scale Parent Child Short Form and the Brief Child Abuse Potential Inventory (BCAP). The former assays physical and psychological abuse, neglect and positive parenting strategies. Straus and Mattingly (2007) developed this 10-item scale from its well-validated parent instrument. The BCAP indicates risk for both child abuse and neglect. Derived from a 160-item instrument, the 33-item BCAP has shown good properties of reliability as well as construct and predictive validity (Ondersma, Chaffin, Mullins, & LeBreton, 2005).

School Readiness and Achievement. We will access SPHERE to measure multiple markers of school readiness, including parenting stress, parent support for children's development, parent-child relationship as well as child's physical, cognitive, and socio-emotional development. Providers also complete the HOME, including subscales that measure parental support of child's learning environment via stimulation and involvement, parent disciplinary strategies, and parent-child interactions. SPHERE also displays results from the ASQ, a parent-completed screening and assessment tool that measures child physical, language, cognitive, and socio-emotional development. Both the HOME and ASQ have performed well in reliability and validity analyses (Squires, Bricker, & Potter, 1996; Totsika & Sylva, 2004).

We will augment stress-related measures with the Parenting Stress Index-Short Form (Abidin, 1995), a 36-item parent report of family distress, child behavior, and parent-child interaction. Incorporating subscales from this well-validated instrument into our evaluation will enrich our understanding of parenting stress and triangulate observational measures of parent-child interaction. This measure will also generate information on parental health.

Domestic Violence. Consistent with HFA, EHS and PAT program theories, we will focus on domestic violence as a benchmark area of interest. SPHERE currently reports parental responses to several domestic violence screening questions. In addition, a field within SPHERE identifies whether home visitors provided a referral for domestic violence services.

Family Economic Self-Sufficiency. Home visitors elicit client self-reports for household income and benefits, employment, educational attainment, and health insurance status, which are entered in SPHERE. To augment these data, we will also access state Department of Public Health records documenting publically-funded child and family medical assistance.

Coordination and Referrals for Other Community Resources and Supports. Each site will report information related to program referral processes, including: families identified for additional services through screenings; families that received a referral to outside services; completed referrals; and number of external agencies with whom the home visiting program has regular communication or a formal relationship. Sites will be required to track this information and enter it into existing or (as needed) newly developed fields in SPHERE.

Qualitative Data. Project aims will guide qualitative data collection efforts. Hence, the schedule of open-ended questions that home visitors will present to clients will address the following themes: strengths and needs of the client families, client expectations of home visiting programs and staff, client perceptions of program and staff effectiveness, and client perceptions of program and staff limitations. Focus groups with agency constituents will cover these same themes with slight alterations. For these gatherings, we will ask participants to communicate their perceptions of the following: client strengths and needs, client factors contributing to

successful program engagement, client barriers to program completion, program effectiveness, program strengths and limitations, programmatic barriers to effective service delivery, and perceived benefits and drawbacks of CoPs and mentor-protégé innovations.

Data Management. Survey development and data collection will be performed using TeleForm™ software, with which professional surveys can be generated for administration. Using a high-speed scanner, TeleForm can be used to scan, clean, and archive data quickly. TeleForm will be used to create paper and pencil surveys along with consent forms, which will be administered by direct service providers during client home visits. Home visitors will be responsible for returning signed consent forms and completed surveys to a centralized site location. Secure U.S. Postal mailing options such as registered mail with priority delivery will be used to return the consent forms and surveys to the evaluation team at quarterly intervals. Alternatively, evaluation team members may retrieve the forms in person for sites located in Milwaukee. All consent forms and surveys will be stored in locked file cabinets located in a locked storage office located within the Center for Addiction and Behavioral Health Research (CABHR). CABHR is housed in the Helen Bader School of Social Welfare (HBSSW) and is a leading research center in securing grant and contract funding at the UW-M.

A data sharing agreement between the evaluation team and relevant state agencies (DCF; DHS) will be reached prior to the project start. Archival records collected from state-level databases (e.g., SPHERE; eWISACWIS) will be transferred to the project evaluators using a Web-based file storage and sharing service (Pantherfile) with secure access available 24 hours a day, 7 days a week. Electronic files are backed up nightly and data and can be accessed by those with permissions from any Internet connection, which will facilitate secure data sharing.

Project staff will enter all survey data into SPSS using a double entry procedure. Master, verification, and cleaned copies of the data sets will be stored on a server for access by the Principal Investigators and routinely saved and stored in a separate location as a precaution against unexpected loss or damage. Data will be further visually inspected to identify computer-related errors or residual errors in programming.

Data Analysis, Interpretation, and Reporting. Capitalizing on the time-series design, a variety of descriptive and comparative quantitative analyses will be conducted to assess site-level performance on benchmark indicators over time. Descriptive statistics (e.g., central tendency; distribution; dispersion) will be used to summarize data, providing numeric and graphical representations of how individual sites are performing. One strength of time-series data is that they can depict cross-sectional estimates of performance at discrete time points as well as trends over time. In addition to analyzing independent sites, data will be examined to descriptively portray aggregate performance among participating sites. Furthermore, data will be analyzed for subgroup variation to determine if findings differ according to salient client (e.g., age; race; gender) or agency (e.g., service duration; home visitor experience and education) characteristics.

Provided descriptive analyses of pre- and post-intervention trends suggest expected change in client outcomes, comparative analyses will be performed to assess whether the observed changes can be attributed to the intervention. The scope of possible inferential statistical methods used to evaluate time-series data precludes detailed description here (see Box & Jenkins, 1976; Enders, 2010; McCleary & Hay, 1980; Yaffee & McGee, 2000). In basic terms, analyses will be comprised of methods aimed to examine a sequence of observations that occur before and after the project start date. In so doing, it is possible to determine if systematic changes in the data take place, if the changes are linear or non-linear, and whether the changes may be attributable to the initiative. Appropriate model selection requires accounting for the

autocorrelation structure in error terms between observations, tested by the Durbin-Watson statistic. Like other analytic approaches, time-series analysis assumes that data are patterned systematically and that errors are random. The Dickey-Fuller unit root test will be used to test for seasonality and stationarity in the data. Assuming the data are monotonic, basic techniques can be applied (e.g., smoothing) to reduce model noise and thereby reveal a more coherent pattern. Segmented regression analysis of interrupted time series data will be utilized to test whether statistically significant level and/or trend changes occurred after the intervention.

Quantitative results will be interpreted in light of the study's methodological limitations, three of which are most salient. First, the proposed design will not follow a panel of participants over time; each discrete measurement point will reflect a different sample composition. In this regard, the evaluation is designed to assess site-level performance, not individual-level change. A second, related limitation pertains to the likelihood that clients who are retained in the sample over time will differ from clients who exit. Analytically, attrition could lead to an overestimation of change attributable to the intervention. Therefore, we will collect demographic and process data to assess whether clients who receive home visitation services for an expected duration of time (i.e., completers), as defined by individual program sites, differ from clients who stop participating prior to program completion (i.e., dropouts). This information will be relayed back to programs, which may lead to enhancements in service delivery that promote client retention and engagement. Finally, it should be noted that there are no standard methods for computing statistical power for time-series analyses. Standard methods used to estimate power have been based on cross-sectional data, which may not be appropriate for longitudinal designs in general and, more specifically, for time-series data. To address this limitation, we will conduct power analyses for differences in means (pre- vs. post-intervention) based on the two-sample t-test. Since the independence assumption is not likely to hold, however, we also will use a first-order autoregressive model to estimate power (McLeod & Vingilis, 2008). For both approaches we will utilize pre-intervention data for means and standard deviations to derive best estimates for effect sizes. Our minimal level of power is 0.8 and we will set the Type-I error rate to 0.05.

Qualitative data will be analyzed using content and narrative analysis techniques. Using content analysis, the co-investigator (Dr. Pate) along with other evaluation team members will code for themes and topics known to be of interest to the project (e.g., parenting, consumer satisfaction). Analyses will also include open-ended coding to capture themes of importance to sample members. Narrative analysis will provide information about the meaning and value that study participants assign to events and issues, including how they understand causality and how they perceive events to be related to each other.

Coded data will be managed through a software package called QSR NVIVO 9, designed to analyze non-numerical, unstructured qualitative data. NVIVO supports processes of coding data in an index system, searching text or patterns of coding and theorizing about the data. NVIVO's user-friendly interface allows themes to be displayed using multiple visualization tools (e.g., charts, maps, models), which will facilitate the dissemination of evaluation findings.

Ongoing improvement in program delivery and client outcomes represents a primary aim of this evaluation. As such, the evaluation team will provide timely feedback to program sites reflecting results from the project's data analyses. We will use multiple channels (e.g., teleconferences, site visits, reports) to communicate with program sites. We will also describe processes involved and insights learned from our multi-pronged evaluation through the CoPs.

Consistent with participatory evaluation designs, however, we intend to incorporate multiple stakeholders in all or nearly all facets of the evaluation. For instance, clients, staff,

supervisors and administrators will supply evaluation data through focus groups. Program staff will be integrally involved in devising site-specific implementation evaluations along with interpreting and applying results. Administrators from local program sites will facilitate the process of collecting and interpreting cost data. In addition, CoPs will present opportunities through which program personnel can review evaluation results and discuss implications for practice. Fostering stakeholder engagement throughout the evaluation may promote local program evaluation capacity, continuous quality improvement, cross-agency collaboration, and ultimately favorable program outcomes.

Methodological Rigor. The design, measurement, and analytic features of the proposed evaluation meet the expected standards for methodological rigor. *Credibility* will be enhanced by augmenting existing data fields archived in administrative databases with well validated measures that reflect the priorities of local programs and state funding agencies. Furthermore, process data will be gathered from multiple sources, including clients, staff, supervisors and administrators, thereby enhancing credibility by ensuring that the voices of all stakeholder groups are represented in the evaluation process. Another strength of the study protocol is its *applicability*, given that it is explicitly intended to inform and measure home visitation in real-world contexts. The time-series design, for instance, is a non-invasive approach that will produce useful descriptive and inferential data. Applicability will be further promoted by the inclusivity and representativeness of the programs and client populations selected into the project.

The proposed methodology will also promote *consistency*, especially by ensuring that all program sites report data to measure mandated indicators in a consistent, uniform manner. Gathering cost data will also increase the generalizability of the evaluation process and its findings, facilitating external comparisons and replication efforts along with state-level policy decisions. Consistency will also be advanced by implementing rigorous analytic procedures for coding and analyzing qualitative and quantitative data. Last, gathering qualitative and quantitative data from multiple stakeholders will reduce mono-method bias and increase *neutrality*, as will the independence of the evaluation team from the home visitation programs and their state funding agencies.

Informed Consent & IRB Approval. Clients enrolled in the selected home visitation programs will be required to sign an informed consent form prior to the collection of survey data. A description of the intervention and assessment protocol, its potential risks and benefits, and general study aims will be communicated. Contact information for project investigators will be provided to participants with instructions to contact Dr. Mersky with any questions or concerns. Prior to study onset, the informed consent form and all study procedures will be reviewed and approved by UW-M's Institutional Review Board (IRB; Federal Wide Assurance #00006171), which is housed administratively within the UW-M Human Research Protection Program (HRPP). UW-M has established administrative policies and procedures for conducting intervention research such as accounting policies and procedures for participant incentive payments. A summary of project activities will be submitted annually to the IRB at UW-M at the time of continuing review, unless monitoring efforts reveal any serious adverse events resulting from study involvement, in which case information will be reported immediately by Dr. Mersky.

Evaluator Experience and Knowledge Joshua P. Mersky, Ph.D., Assistant Professor, Department of Social Work will be the Principal Investigator; and Dr. James Topitzes and Dr. David Pate, Assistant Professors, Department of Social Work will serve as Co-Principal Investigators. Dr. Mersky's research interests include the design and evaluation of prevention and early intervention programs, especially for children and families at risk of abuse and neglect.

Dr. Mersky will be responsible for oversight of all aspects of the evaluation project, including: the evaluation budget, personnel, design, and implementation; coordinating planned activities and ensuring their quality (e.g., literature reviews, reports, evaluation research); managing timelines and project coordination; and, leadership in analyses and preparation of manuscripts and presentations. Dr. Topitzes has expertise in early childhood intervention, program evaluation, and child maltreatment. Dr. David Pate is a qualitative methodologist with extensive experience conducting participatory research with economically disadvantaged, minority populations. (See attached resumes and bio sketches for more detailed information).

ORGANIZATIONAL INFORMATION

The governor of the State of Wisconsin has designed the Department of Children and Families (DCF) as the lead agency to administer the funds for the Maternal, Infant and Early Childhood Home Visiting Program. The Department of Children and Families is a part of the executive branch of sate government with a mission to promote the economic and social well-being of Wisconsin's children and families. It has the responsibility for the human service program areas of child and family services; including prevention initiatives and service integration, the Head Start State Collaboration Office, the child welfare programs, the Temporary Assistance for Needy Families Program (TANF), Child Support, and Child Care. DCF administers a number of federal and state funded programs, including home visitation, child welfare services, child abuse and neglect, child care, child support, and TANF with approximately $1.1 billion on an annual basis.

DCF has a full-time staff person as the home visiting consultant in the Prevention and Service Integration Unit of the Bureau of Safety and Well-Being. The Bureau of Safety and Well-Being (BSWB) is responsible for prevention and early intervention efforts across Wisconsin. The goal is to help families overcome the struggles that limit their ability to care adequately for their children before they come to the attention of the child protective services or juvenile justice systems. BSWB is charged with the integration of the multiple programs and services that typically touch the lives of Wisconsin's vulnerable families.

DHS and DCF have an on-going partnership. The two departments will have been working closely on many initiatives involving young children and their families including the writing of the State Home Visiting Plan. The two departments will have an equal relationship in managing the program. This is an opportunity to continue the work to improve the health and developmental outcomes for at-risk children and their families in partnership with other key state agencies such as Head Start Collaboration Office, Children's Trust Fund, Substance Abuse and Mental Health Services, Birth to Three, and Department of Public Instruction.

At this time, the State remains committed to maintaining current levels of state General Purpose Revenue ($985,700) and TANF ($992,000) spending on evidence-based home visiting programs. Staff are encouraged to explore related federal and other grant opportunities that can complement the existing funding sources for home visiting.